FINAL EVALUATION OF THE NIGER FAMILY HEALTH AND DEMOGRAPHY PROJECT

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ABBREVIATIONS

ACA	Association Conseil pour l'Action
AIDS	acquired immunodeficiency syndrome
ARIEPS	Antennes Régionale d'Education pour la Santé
ASV	village health agent
CARE	Cooperative for Assistance and Relief Everywhere
CBD	community-based distribution
CFA	West African franc
CNSF	Centre Nationale de Sante Familiale
CNSR	Centre Nationale de Santé Réproductive
CONAPO	National Population Commission
CSE	epidemiological surveillance center
CYP	Couple Years of Protection
DEP	Direction des Études et de la Programmation
DHS	Demographic and Health Survey
DPF	Directorate of Family Planning
EM	essential medicines
EPA	public administration entity
FAC	Cooperation Francais
FED	Fonds Européene de Developpement
FHI	Family Health International
FP	Family Planning
GON	Government of Niger
GTZ	Association for Technical Cooperation (Germany)
HKI	Helen Keller International
HNL	Lamorde National Hospital
HNN	Niamey National Hospital
HNZ	Zinder National Hospital
IEC	information, education, and communication
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
MCH	maternal and child health
MOH	Ministry of Health
NFHDP	Niger Family Health and Demography Project
NGO	nongovernmental organization
NHSSG	Niger Health Sector Support Grant
NPA	nonproject assistance
NPHSS	Niger Population and Health Sector Support Project
OC	oral contraceptive
ONPPC	Office Nationale des Produits Pharmacetiques et Chimiques
OPTIONS	Options for Population Policy Project

OR	operations research
ORS	oral rehydration solution
PAIP	Action Plan for Priority Investments
POPTECH	Population Technical Assistance Project
PVO	private voluntary organization
QAP	Quality Assurance Project
RAPID	Resources for the Awareness of Population Impacts on Development Project
REDSO	Regional Economic Development Services Office
RFP	request for proposal
SM	Social Marketing
SNIS	national health information system
SOMARC	Social Marketing for Change Project
SOW	Scope of Work
SPT	standard treatment protocols and prescriptive guidelines, (Strategie Plainte-Traitement)
STD	sexually transmitted disease
TA	technical assistance
UNICEF	United Nations International Children Emergency Fund
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENT

The team wishes to thank everyone at USAID for their assistance, counsel and encouragement during this exercise, and to express its admiration for their obvious commitment. Starting with the Director's eloquent words on our first day of work, those of us who were in Niger on assignment a year ago were struck by how much more focused and energized the Mission now seems. It has a leadership role to play in Niger, the tools with which to play it, and we wish it well, with optimism.

EXECUTIVE SUMMARY

Final evaluation of the Niger Health Sector Support Grant (NHSSG) and the Niger Family Health and Demography Project (NFHDP) were conducted from August 9 to September 10, 1995, by a seven-person team, assisted by four Nigerien counterparts. The team conceived of the evaluation as a forward-looking exercise, and focused on recommendations for the future. One reason for this was the wealth of evaluative material already developed on the projects themselves and on the strengths and weaknesses of Nigerien health systems. A second was the need to provide guidance to the new Niger Population and Health Sector Support Project (NPHSS), for which a contract will be awarded shortly.

Achievement of the goals of the two projects has been mixed. The NHSSG, especially the portion funded with nonproject assistance (NPA), was slow to develop due to expectations that were unrealistic and poorly understood. A mid-course correction reduced the number of policy reform objectives and clarified them; and this helped to achieve some successes. These successes included the development of a national health information system, as well as nascent systems for cost recovery and cost containment in hospitals, other health facilities, and drug distribution. It furthered the debate on a national population policy, and contributed to the process of decentralization of health services management.

The NFHDP also contributed to the decentralization process through the testing of service delivery models and strategies, promotion of social marketing and other modest private sector initiatives, and enhancement of operations research capabilities. Nonetheless, national service standards remain far from acceptable in quality and coverage. Information, education, and communication (IEC) efforts have been largely ineffectual, and poor communications at all levels have limited the sharing of effective interventions.

Unpredictable events, ranging from labor strikes to currency devaluation to a meningitis epidemic, were significant hindrances to both projects. Equally damaging was the lack of effective coordination between the NHSSG and NFHDP. Efforts on all sides notwithstanding, having two complex projects operating concurrently was overly taxing on available systems and personnel in Niger, and effective synergy between the two was not fully realized.

Nonetheless, thanks in large part to the NHSSG and the NFHDP, Niger is at a key point of departure in the development of its national health systems and infrastructure. While still fragile, the elements of a decentralized health management system are in place. Valuable lessons have been learned from trials of service and management models in different parts of the country, which could, with improved communications, be used nationwide. While not deep, the pool of technical talent is of good quality, providing a sound base for expansion. Finally, motivation among decision-makers is high, especially when they feel confident that funders are committed to true partnerships and building of Nigerien capacity.

The evaluation team recommends the continued nurturing, through technical assistance and budgetary support, of initiatives that are critical to the establishment and maintenance of a decentralized health system. These include the national health information system, cost recovery at all levels, national population policy dialogue, demographic analysis and operations research.

The team also recommends redoubled efforts in areas critical to expanding access to and quality of services, the principal goal of decentralization. These include increased attention to the skills, attitudes, and supervision of service providers; reorientation of the entire IEC effort in health to emphasize national capacity building and community orientation; continued improvement in contraceptive logistics; and substantial expansion of the fledgling social marketing effort, with particular emphasis on its integration into public sector health systems.
The team urges vigorous expansion of efforts to mobilize the untapped resources and energy of the private sector in the expansion of health services. The experience of international organizations, many supported by the NFHDP, in developing service models and credit schemes must be more effectively disseminated.

Future use of nonproject assistance as a funding mechanism should be carefully considered. NPA should probably be limited to implementation of policy reforms already adopted until the Government's capacity to deal with more complex schemes is enhanced. And under any circumstance, all support from the United States Agency for International Development (USAID) to Niger should be offered under a single umbrella funding mechanism.

The evaluation team urges careful and focused attention to the admittedly mundane subject of donor coordination. The Government of Niger (GON) must, of course, take the lead in insuring overall coordination of foreign assistance. But USAID can set an important example by establishing rigorous interagency coordination mechanisms and standards for those organizations which use its funds, and ensuring close and continuous communications with the government.

Through the process of clarifying its own programmatic priorities, USAID has positioned itself to play a lead role in developing an effective, forward-looking partnership between the international donor community and the GON. No effort should be spared in moving this forward. Niger is at a point of great opportunity for strengthening its health systems; and the country must have success in the near term, or a still fragile opportunity could evaporate. Failure to vigorously build on the steps taken under earlier projects would have serious consequences in terms of dwindling external support and further erosion of the health care available to the people of Niger.

LIST OF RECOMMENDATIONS

1. Future USAID support in the health and population sectors to the Government of Niger should be offered under only one umbrella funding mechanism to minimize the problems inherent in having support for similar initiatives originating with different providers. (p. 8)

2. The issue of donor coordination should be given substantially greater attention than in the past. For all United States donors and contractors, resident in-country or otherwise, USAID should establish an obligatory system of coordinating meetings and project information sharing, with agendas and minutes, and encourage joint strategic planning. USAID should propose a similarly obligatory coordination model to the MOH/Directorate of Population for the entire donor community and offer, through the Niger Population and Health Sector Support Project (NPHSS) contractor, all necessary logistical/technical assistance needed to make it operational. (p. 9)

3. Training of counterpart specialists to the same level as outside experts should be a specific and stated objective of all technical assistance offered under all subsequent USAID-funded projects or contracts. (p. 9)

4. The Directorate of Population should be strongly supported under the new project, so that it can continue the process of population policy development and awareness creation. (p. 13)

5. In order to enhance its influence on population policy development and implementation, the Directorate of Population should be moved to a location more central to the policy and planning process. (p. 13)

6. The MOH should set as a firm goal the development of detailed five-year strategies, with timelines, for the design and implementation of individual district health plans. The strategies should outline the steps required to institutionalize cost-recovery measures, regularize drug supply and distribution, institutionalize in-service training and supervision, and encourage and maintain community participation. (p. 14)

7. As the cornerstone of a decentralized system, district chief medical officers and their "equipe cadres" should be formally granted the necessary managerial and financial authority, with strict accountability, to supervise health care providers in implementation of integrated family planning and child health services. (p. 15)

8. For the foreseeable future, the use of nonproject assistance in Niger should be limited to implementation of health sector policy reforms which have already been adopted by the Government, and only when particulars are understood and agreed to by all parties

involved. Complex applications of NPA should be deferred in favor of more traditional forms of project support. (p. 16)

9. The MOH should immediately update "decret 89/075," which details job descriptions for health personnel, recruitment norms, and conditions for applying for training opportunities. The decree places limitations on assignment of nurses and doctors to rural health facilities and district hospitals. (p. 18)

10. The MOH must establish and disseminate formal standards for hiring staff at all levels of health facilities to guide department/district planners. The national Health Development Plan suggests broad guidelines, based on a WHO model, but is not specific about the number of personnel by type of facility. (p. 18)

11. As noted, the World Bank is helping the MOH develop its personnel systems and norms, articulate training needs, and build its database. USAID should play a supportive role in this process, providing specific technical or program assistance as require. (p. 18)

12. The MOH's Management Committee for the local currency account should be given the budgetary support necessary for wide dissemination of the new procedures manual for proposal submission and subproject management. The Committee's management problems should be addressed, and its project portfolio expanded. (p. 20)

13. USAID should work more closely with other donors, especially the FED, in encouraging and supporting improvements in MOH drug distribution infrastructure and operations. Continued TA should also be provided through the new project to improve procurement, inventory control, and distribution consistent with the goals of decentralization, especially at the district level. (p. 23)

14. USAID should provide short-term TA through the new project to help the MOH complete reform measures already initiated in pharmacy management, personnel management, financial management, and cost recovery at the national hospitals, and to assist the MOH in conversion of departmental hospitals into EPAs. (p. 27)

15. Given a clear commitment on the part of the MOH to the urgent implementation of a national cost-recovery program, USAID should, through the new project, continue providing training and technical assistance in development of drug management systems, financial management systems, management information systems, and supervision procedures required to make this possible. (p. 33)

16. Technical assistance for the SNIS should be maintained, drawing on international experience, especially in disease surveillance and operations research. The goal should be effective utilization of information at district levels, full integration of a national system, and long-term sustainability. (p. 34)

17. In response to the MOH's clear commitment to SNIS and to staff proficiency in its use, the new project should include in-country, short-term courses for SNIS personnel in the development and maintenance of computer systems. It should also train MOH teams to provide regular TA and maintenance to systems at regional and district levels. (p. 34)

18. The Ministry of Health must express its clear commitment to improving the quality of family planning/MCH services by upgrading service skills, changing attitudes of health care workers towards their clients, and updating service and sanitation standards. A two-day national workshop is proposed to sensitize health workers at all levels to their roles and responsibilities in this area. Such an approach has met with success in a similar situation in Mali. (p. 36)

19. Supervision at all levels of the health system and training in supervisory techniques are presently weak, especially in family planning service delivery. A priority under the new project should be training for supervision at district and subdistrict levels. (p. 36)

20. Numerous training interventions will be required to make possible the successful implementation of a national, decentralized primary health care strategy. The new project should be prepared to provide these interventions, starting with the preparation of a detailed inventory of training resources available in Niger, as described above. (p. 38)

21. Under the NPHSS (the new project), the IEC unit of the Ministry of Health should be transformed through training and technical assistance into an agency fully capable of planning, implementing, and evaluating health information and behavior change campaigns at all levels. (p. 40)

22. The new project should provide the MOH with a long-term health education/IEC advisor, preferably a Nigerien or French-speaking African. The advisor will be responsible for developing an effective collaborative partnership with the IEC unit, and providing whatever services are required to fully professionalize the Unit. (p. 40)

23. To achieve the desired levels of professionalism on the MOH IEC team, a United States university with a strong behavior change-oriented health education program should be contracted to provide three in-country, for-credit courses each year for two years. These would be designed for health and family planning IEC specialists in the MOH and NGOs. Advanced training for selected personnel could be provided as appropriate. (p. 41)

24. IEC training should be developed for community health clubs, "leaders d'opinion," and other community agents. Focus would be on community research and the planning of communication strategies based on findings. The new project should also test models for motivating community workers by linking their work to modest income generation. (p. 41)

25. The MOH should take the lead in molding its IEC team and contractor technicians into a partnership that will provide maximum support to community-based health education efforts throughout the country. The NPHSS should ensure that this team has the necessary logistical and material support to fully carry out its national mandate. (p. 42)

26. Volumes of contraceptives being handled by the DPF warehouse and their distribution to the public and private sector agencies should be carefully examined to ensure that they are actually being distributed and issued to end users. (p. 45)

27. An audit of stocks at the various points of issue should be undertaken to ensure that products are not out of date before further requisitions are made through USAID/Washington. The computerized tracking system should be used to monitor distributions down to the level of health centers. Stock and sales recording systems should be incorporated into the SNIS system and TA commissioned to develop buffer stock levels and timely ordering. (p. 45)

28. As decentralization proceeds, there will be a continued need for operations research to test new models of program management and service delivery, new approaches to private sector programs or the financing of rural services. The Quality Assurance Project has proven the importance of OR, and substantial support for additional such initiatives should be provided under the new project. (p. 46)

29. The social marketing program must make every effort to gain distribution in non-AIDS/STD outlets in order to normalize the product and gain public acceptance. GON should communicate the FP and AIDS/STD prevention messages in a generic way, in conjunction with the branded SM activity. This will require IEC coordination to ensure common messages. (p. 50)

30. USAID should encourage the GON to move legislation which would allow other products such as vitamins and oral rehydration solution (ORS) to be sold via the SM distribution system, eventually leading to open sale of OC's. This will help the SM program become more self sustaining and will aid acceptance of contraceptives on the open market. (p. 50)

31. The SM program should publicly market and distribute its products where it can economically do so, and link up with other community-based distribution (CBD) activities to gain access to the chain of activity down to village areas. USAID should ensure that practical programmatic interfaces occur. (p. 50)

32. Establishment and expansion of health facilities and services in the private sector should be vigorously encouraged through access to credit, publication of guidelines and regulations, and private sector-oriented training. This is a resource ready for dynamic growth. (p. 53)

33. USAID should construct its programs whereby donor activities complement each other, minimize duplication of effort, and develop a coherent private sector strategy. Regular communications of both design and progress of programs should be set up among all private sector donors. (p. 53)

1. METHODOLOGY OF THE EVALUATION AND STRUCTURE OF THIS REPORT

Under the Population Technical Assistance Project (POPTECH) auspices, a seven-person evaluation team spent about four weeks in Niger from August 13 to September 9, 1995, to undertake the final evaluation of two projects ending concurrently: the Niger Health Sector Support Grant (NHSSG) and the Niger Family Health and Demography Project (NFHDP). (See Appendix A for the complete Scope of Work for this evaluation.) The team collected data through numerous meetings with public and private sector officials and other personnel in Niamey, Niger, and through a series of field visits to the interior of Niger. (See Appendix B for a listing of persons contacted.) The team also undertook an extensive document review while in Niger and before arriving in country (Appendix C).

As outlined in the Scope of Work (SOW), different members of the POPTECH team were responsible for data collection and analysis of different elements of the projects. Full participation by a representative of the Regional Economic Development Services Office (REDSO) in Abidjan contributed an important regional perspective to our investigations. Most importantly, throughout the evaluation, we were helped by the participation of four senior Nigerien counterparts from the Ministry of Health (MOH), the Ministry of Planning, the Directorate of Population (Direction de Population), and the United States Agency for International Development (USAID) Mission. This partnership made possible a far more insightful treatment of the issues than would otherwise have been possible. We were fortunate to have been part of a group that is united in its commitment to improve the health of the people of Niger.

From the beginning, perhaps to a greater extent than usual with such evaluations, the team conceived of this as a forward-looking exercise. Much has been written about Nigerien health and family planning programs and systems, their strengths and weaknesses, and the impact realized from international assistance, especially under NHSSG and NFHDP. Rather than "putting old wine into new bottles" by restating what is already well known, we endeavored to look ahead, and to set a clear conceptual basis for initiatives to come. We were encouraged in this approach by USAID Mission officials, including the director and officials at junior levels, and were guided by the directions set forth in the Mission's new Strategic Objectives.

Consequently, while careful attention is paid in this report to the achievement or nonachievement of the stated goals of the NHSSG and NFHDP, with specific reference to progress since their respective midterm evaluations, the team considers the essence of this report to be in its recommendations for the future. Our debates were most intense, and our scrutiny of the lessons to be learned from past activities were most detailed regarding recommendations for the future. In each section of the report we acknowledge and comment on the past, then attempt to look creatively to the future. We note where we feel contractor interventions have been successful or otherwise, and conclude with summary comments on the performance of individual donor

organizations involved. Finally, we offer an assessment of the role of USAID in enhancing a process of constructive change and growth.

2. BACKGROUND AND COUNTRY CONTEXT

2.1 History of Health and Population Programs in Niger

The United States support for health programs in Niger began in 1976 with a small grant in support of an Africare project in Diffa. This was followed in 1978 by the Rural Health Improvement Project, USAID's first major health intervention in Niger. Well into the 1980s, however, the Government of Niger's pronatalist policies prevented the incorporation of family planning into any health programs. Even as late as 1987, only a few private urban facilities in the country were allowed to provide family planning services.

By 1986, however, deteriorating economic conditions and heightened awareness of the impact of unchecked population growth led to a change in government attitudes. The Niger Health Sector Support Grant (NHSSG), initiated to support policy dialogue and health sector reform, contributed to this process. The 1987-1991 Development Plan included a section on the socioeconomic implications of uncontrolled demographic pressures, a first for Niger. Finally in 1988, with technical assistance from Columbia University and the Options for Population Policy I (OPTIONS), the provision of contraceptives services was legalized and the Directorate of Family Planning (DPF) was created within the Ministry of Social Development. The Niger Family Health and Demography Project (NFHDP) was designed at this time, to complement new policies with research and services.

Locating family planning under the Ministry of Social Development, rather than the Ministry of Health, raised issues of status which were sensitive at the time, and have remained so. Not until recently, when the MOH was reorganized, was the family planning directorate abolished and the program incorporated as a new division under the Directorate of Maternal Health in the MOH. This was done to enable the Ministry to integrate family planning into maternal and child health services. But downgrading it to division rather than department status created an ambiguity which persists as to the relative importance of family planning in the overall health picture in Niger. It is, however, an internal issue, in which donors are well advised not to involve themselves.

As NHSSG and NFHDP come to a close, it is important to understand their evolution and accomplishments. But it is even more essential to recognize how much remains to be done. While acknowledging progress made, in terms of systems developed and policies enacted through these programs, it is important to recognize the serious nature of Niger's needs. The country's mortality and fertility rates are among the highest in the world. Its health infrastructure effectively reaches little more than a third of the population (and a far smaller percentage outside of urban centers). Serious deficiencies persist in the quantity and skills of health personnel at all levels. Given all this, the country, in partnership with its external supporters, must bring even greater wisdom and energy to the task of mitigating these health conditions. Success is essential, and in more than incremental steps.

2.2 The Niger Health Sector Support Grant

NHSSG (683-0254/276) was conceived as an attempt to combine project and nonproject assistance in bringing about policy and institutional reforms in the health sector. It was USAID's earliest experience with the use of nonproject assistance (NPA) in health and population, and thus served as an important laboratory for this approach to development assistance. Began in 1986, when concluded it will have absorbed US$10.5 million in resource transfers under its NPA component, and US$10.8 million in project support for long- and short-term technical assistance, training, evaluation, and audit services. One major contractor, closely assisted by two subcontractors, implemented the grant.

The midterm evaluation of NHSSG, conducted in 1989, and a subsequent "interim evaluation" in 1992, concluded that the ambitious list of policy reforms on which delivery of NPA funds were conditioned had, in most cases, not been enacted. The evaluators recommended that the number of reforms be reduced and prioritized, and the focus should be on population policy; cost containment in hospitals; cost recovery at nonhospital service points, drug purchasing and distribution; and development of the national health information system. All reforms would be geared to enhance decentralization of health services management in Niger.

This report takes the achievements of the reduced list of reforms as recommended in the interim evaluation as its point of departure for assessing the lessons learned from the NHSSG and for recommending priorities for future assistance programs. The report concludes that, after a slow start drawn out over several years, important progress has been made in institutionalizing aspects of a truly decentralized, more efficient health system. But progress must be much swifter in the next few years if fragile beginnings are to become a vigorous and flexible whole.

2.3 Niger Family Health and Demography Project

NFHDP (683-0258) was authorized in June 1988 to build on recent government policy shifts by expanding family planning service programs and demographic research in Niger. Its purpose was to "strengthen the capacity of Nigerien institutions to plan, support, and monitor family health services on a national basis, and to produce and use demographic analysis for national planning." On conclusion, the NFHDP will have expended US$21.5 million under a series of projects implemented by one major contractor and eight other contractors of varying sizes and mandates.

The 1991 midterm evaluation of the NFHDP noted "considerable progress" under the project, especially in areas of contraceptive logistics and supply, planning and management of decentralized systems, technical training, and social marketing. The 1991 evaluation praised the progress of the demographic research/analysis component of the project in analyzing census and Demographic and Health Survey (DHS) data and thus contributing to formulation of a national population policy.

At the same time, the 1991 midterm evaluation expressed serious concerns as to the quality and accessibility of family health and family planning services, especially in rural areas. Despite vigorous information, education, and communication (IEC) materials production, the evaluation questioned the effectiveness of underlying IEC strategies, and the realism of stated contraceptive prevalence targets. Among other things, it urged adoption of more realistic family planning goals; more effective efforts to decentralize health program planning and target lower levels of the health system for service delivery; and further development of the capability to generate and disseminate demographic data.

While significant progress has been achieved in these areas, this current report concludes that overall project performance is only modestly successful. Quality and coverage are the focal concerns in any project with a major service component. In Niger, neither of these aspects of the national health and family planning program is yet strong. Many, perhaps most, of the reasons for this may have been outside of the contractors' control. Nonetheless, it prevents the evaluation team from expressing more than partial satisfaction.

3. THE LESSONS OF SEPARATE PROJECTS IMPLEMENTED TOGETHER

3.1 Mutual Reinforcement or Duplication of Roles?

While conceived with different purposes in mind and funded through different mechanisms, the NHSSG and NFDPH have been part of one whole. They were implemented concurrently, had similar overriding objectives, and involved some of the same personnel, especially within the Government of Niger (GON). Thus it is helpful, not only to assess the accomplishment of their individual goals, but also to look at the impact of their overlapping mandates. In the interest of future programming decisions, it is important to consider the extent to which the synergy between the two projects did further the overall mission of health and population assistance in Niger.

Although not explicitly mentioned, the formulation of each project implied a degree of mutual reinforcement. For example, in terms of national planning, it was intended that NFHDP would submit to the MOH at the central level a family planning implementation plan by March of each project year. At the same time, the NHSSG would reinforce planning capacity at the department and district levels through its emphasis on systems development.

As another example, with respect to family planning services it was intended that the NFHDP would recommend policies and test approaches for delivery of services down to the most peripheral level. This would be reinforced by the NHSSG, which, as a result of government implementation of policies specified under its "Conditions Precedent," would ensure a decentralized approach to national health resource allocation and personnel management.

The desired concurrence of activities and achievements might have occurred had the national context been stable. However, both projects were implemented over a period of change and great uncertainty in the Nigerien sociopolitical environment. Factors including a currency devaluation, a major change in the country's form of government, an outbreak of a meningitis epidemic, and a rash of crippling labor strikes all militated against effective project synergy.

Furthermore, coordination between the projects, especially at the national level, was inadequate. The NHSSG was managed under the Ministry of Health, the NFHDP under the Ministry of Social Development. A coordinating committee chaired by the two Ministries' Secretaries General wielded no particular authority over contractors, whose technical assistance personnel failed to consult with each other as appropriate (see Section 3.2). If their efforts were cohesive, they might have been able to work through and even draw strength from obstacles they faced, but too often this was not the case.

Even under trying conditions, great effort was expended by contractors and counterparts alike, and with some success. But in large part, the team concluded that having two complex projects

operating concurrently asked too much of available systems under the conditions present in Niger.

RECOMMENDATION:

1. Future USAID support in the health and population sectors to the Government of Niger should be offered under only one umbrella funding mechanism to minimize the problems inherent in having support for similar initiatives originating with different providers.

3.2 Issues of Donor Coordination

Donor coordination is not a new problem in the international development context. Too often, promising programs fail because agencies do not communicate their ideas to each other, collaborate on strategic planning, or share lessons learned from initiatives that succeeded or failed. Among other results, the financial implications of such lost opportunities can be substantial.

In Niger, poor coordination within the donor community itself has frequently hindered the development and maintenance of effective partnerships on all sides with debilitating consequences. Given its severe limitations in resources and manpower, the country cannot afford the luxury of organizations that "do their own thing" without keeping others informed or involved. The evaluation team heard complaints from both government and donor agencies about lack of information on the activities of agencies with whom they were supposed be working, and of time lost seeking information which should have been systematically provided.

The team did observe some examples of effective coordination. For instance, the successful development of the national health information system (SNIS) was due in large part to consistent, focused collaboration between the MOH, NHSSG contractors, and the World Health Organization (WHO). But such exceptions only emphasize that coordination has been inconsistent and often nonexistent. The result has been dissatisfaction and confusion, most importantly on the part of government counterparts.

For example, while the NFHDP supported nine U.S. contractors, many of the contractors said they had little or no familiarity with the activities of most of the others. In at least one instance, different projects supported by the same agency were unfamiliar with each others' work. While roles and mandates may vary technically and geographically, lack of a general awareness invariably results in missed opportunities to share useful information and/or resources.

The GON must feel fully empowered to take the lead in coordinating the efforts of all external agencies as they pertain to national development. In the health and population sectors, the MOH and the Directorate of Population have the responsibility for this role, and they have discussed with donors steps that should be taken to enhance their effectiveness in this area. Their job will be

made immeasurably easier if the donor community works together in terms of communication and coordination.

For contractors supported by USAID funds, regular exchanges should be made obligatory and coordinated by the Mission. In addition, USAID, in collaboration with the GON, should insist on regular information sharing among the entire donor community. Some such mechanisms already exist, but they must be strengthened.

RECOMMENDATION:

2. The issue of donor coordination should be given substantially greater attention than in the past. For all United States donors and contractors, resident in-country or otherwise, USAID should establish an obligatory system of coordinating meetings and project information sharing, with agendas and minutes, and encourage joint strategic planning. USAID should propose a similarly obligatory coordination model to the MOH/Directorate of Population for the entire donor community and offer, through the Niger Population and Health Sector Support Project (NPHSS) contractor, all necessary logistical/technical assistance needed to make it operational.

3.3 Relationship Between Contractors and Counterparts

A discussion about the relationship between contractors and counterparts is covered in the section on donor coordination, but the evaluation team felt the need to make an additional comment on these relationships as reflected in these projects. This is because, frequently, we encountered contractors who assumed an unending need for external technical assistance (TA) on the part of Nigerien institutions. Although the Nigerien talent pool is thin now, it has the potential to eventually meet national needs substantially on its own.

We feel it is imperative that all subsequent TA be conditioned, from the outset, on establishing specific partnerships for the training of Nigerien counterparts in all aspects of a particular discipline as an integral part of any TA initiative. The openness of Nigerien institutions to such assistance will be immeasurably enhanced when it is clear that assistance is offered with an objective to training Nigerien nationals to the same level of expertise as outside specialists.

RECOMMENDATION:

3. Training of counterpart specialists to the same level as outside experts should be a specific and stated objective of all technical assistance offered under all subsequent USAID-funded projects or contracts.

4. THE NHSSG: SUCCESSES, FAILURES, AND IMPLICATIONS FOR THE FUTURE

4.1 Policy Reform

As has been extensively documented, the most innovative aspect of the NHSSG—its use of nonproject assistance to bring about policy and institutional reforms in the health and population sectors—was slow to evolve. Because of this, the 1992 interim evaluation recommended that the list of targeted reforms be scaled down. Subsequent performance made possible the ultimate release of all "tranches" of grant funds. Nonetheless, progress has been slow in the policy reform area. The evaluation team focused its analysis on the steps that should be taken to maintain the momentum in developing systems consistent with a better planned, better managed, decentralized health sector.

Major health sector policy reform achievements of the NHSSG include a national commitment to cost recovery and ratification of a law to this effect by the Parliament; reorganization of the Ministry of Health to include SNIS and other important directorates; and formulation of an Essential Drugs Policy and an approved essential drugs list. More broadly, NHSSG made possible the development of significant momentum in three important areas.

4.1.1. Health Sector Planning

Capacity building for the planning process was one of the institutional reforms required by the NHSSG, and the most significant activity occurred since the second quarter of 1993. While it is difficult at this early stage to assess the particular impact of population policy implementation on overall health planning, technical assistance provided under both this project and the NFHDP made a significant contribution to the process. The committee that developed the GON's five-year health plan drew extensively on the 1988 census results, the Resources for the Awareness of Population Impacts on Development Project (RAPID) model of population projections to the year 2020, and the DHS.

The government's *"Plan de Developpement Sanitaire 1994-2000"* provides a wealth of data for national and international planners and evaluators. Completed this year, it is presently being circulated to all departments and the Urban Commune of Niamey. It will serve as the framework within which each department develops its health plans, focusing on the Plan's ten priority problems, eight strategies, and 57 suggested activities.

Impressive in its scope, the *Plan de Developpement Sanitaire* could be considered overly ambitious in the current Nigerien socioeconomic context. On the other hand, it does not mention expected sources of financing, nor the coordination mechanisms that will ensure standardization and prevent duplication. But as a blueprint it is impressive, and its very ambitiousness is the

strongest argument there is for pushing ahead without delay with the decentralization process to give departments and districts choices to which to apply their new skills (when achieved) and authority.

4.1.2 Population Policy Reforms

The population policy reform requirement of the NHSSG also overlapped with the NFHDP. It was intended to strengthen the capacity of Nigerien institutions to plan, support, and monitor family planning services on a national basis, as well as to produce and use demographic analyses for national planning.

Despite the uncertain sociopolitical environment within which the demographic component of the NHSSG was carried out, the Directorate of Population, in collaboration with the Directorate of Statistics and National Accounts and with ongoing support of the OPTIONS I and II projects, realized some major accomplishments, including

- Conduct of the 1988 National Census;
- Conduct of the DHS;
- Approval of the National Population Policy Statement at the executive level (August 1992 Prime Minister's "ordonnance"), and passage by Parliament;
- Development of a computerized awareness model on population and development in Niger, targeted to policy-makers;
- Publication of a brochure on population and development ("Appel a l'Action");
- Production of a video for World Population Day, 1994;
- Development of a national database (Fichier National des Localites);
- Action Plan for Priority Investments (1996-2000); and
- Observational study tour for policy-makers and technicians.

(Unfortunately, one sequel to the study tour was a high turnover of key people, which left the Directorate of Population without the resources to expand population awareness to regional and district levels as planned. The National Population Commission (CONAPO), was only recently able to begin sending teams to conduct awareness campaigns and set up regional population policy groups in August.)

The impact of these initiatives was evidenced at the highest policy levels. At a July 1994 "open house" at the Directorate of Population, the Prime Minister of Niger articulated his belief in the relationship between population and development. Later, in an April 1995 address to the Parliament, he confirmed the GON's willingness to "significantly modify the demographic indicators, establish the conditions to improve and increase the educational level of girls, adopt texts and conventions related to women's status in order to halt the discriminations toward women."

The Directorate of Population, presently located in the Ministry of Social Development, Population, and Promotion of Women, also serves as the secretariat for CONAPO. Niger's highest level advisory committee on population matters, CONAPO was recently (March 1995) strengthened by ministerial "arretes" which created three technical committees, focusing on policy, communications technology, and IEC. When fully developed, these committees will provide national expertise to the continuing implementation of population policy, supported by departmental and district-level counterparts being set up during CONAPO's awareness campaigns.

With so many organizations and entities involved in the development of population policy and promotion of population awareness, the Directorate of Population is clearly central to the entire process, and will need continued support. This includes the technical assistance, materials development, and training required to carry the process forward and to promote awareness of and dialogue on population issues at all levels.

The Directorate of Population is presently located within the Ministry of Social Development, where it was placed to give it broader impact. But, the result has been to substantially remove the Directorate from a position of influence in the national policy/planning dialogue to one of only secondary influence. Population policy is not a priority with the Ministry of Social Development, and there are severe limitations on technical and logistical resources available to the Directorate for carrying out its informational and promotional mandate. Its impact, and the importance of the population variable, would be significantly enhanced if it were in a location more central to national policy making, as in its previous home at the Ministry of Planning.

RECOMMENDATIONS:

4. The Directorate of Population should be strongly supported under the new project, so that it can continue the process of population policy development and awareness creation.

5. In order to enhance its influence on population policy development and implementation, the Directorate of Population should be moved to a location more central to the policy and planning process.

4.1.3 Decentralization of Health Services

The NHSSG has contributed significantly to the process of changing Niger's public health system from a highly centralized operation, with neither flexibility nor opportunity for innovation, to a system where health personnel at department and district levels are becoming empowered to plan and manage their own activities. While the difficulties involved in the decentralization process should not be underestimated, there are indications that decentralization in Niger is now "politically correct" (Frere and Keith, March 1994) and the wave of the future. The following indications were made possible by the NHSSG, unless otherwise noted:

- The evaluation team confirmed that MOH central management has transmitted guidelines to district health teams for preparation of action plans and related budgets to take effect in January 1996.

- The MOH has launched a national nonhospital, cost-recovery program, and is testing methods for improving the drug distribution system.

- Decentralization of the national health information system (SNIS) to district levels is under way, with detailed planning guidelines provided to departments and districts.

- Several donors are supporting projects which test different elements of decentralized health systems management. These include Cooperation Francais (FAC) in Zinder, Niger; the Quality Assurance Project (QAP) in Tahoua, funded by University Research Corporation (URC); and Bamako Initiative activities in drug distribution and cost recovery in Maradi, supported by the United Nations International Children Emergency Fund (UNICEF).

- Cost-recovery models have been tested with varying results (see below) in the health districts of Boboye, Illela, and Say.

- Several district-level, in-service training teams have been established, and training materials developed. These supplement in-service training for district medical officers provided by the Belgian-supported training program at CIMEFOR.

- The government has stated its intention to have all health personnel recruitment and salary administration handled at the departmental level starting in January 1996.

Thus, decentralization has been widely tested in the field and the concept has been largely accepted. Substantial difficulties lie ahead when a full model is put to work. Effective decentralization calls for fundamental change, especially in its delegation of managerial and financial authority to implementing levels of the health system. Those responsible will need time and patience in adjusting to new roles and realities.

RECOMMENDATIONS:

6. The MOH should set as a firm goal the development of detailed five-year strategies, with timelines, for the design and implementation of individual district health plans. The strategies should outline the steps required to institutionalize cost-recovery measures, regularize drug supply and distribution, institutionalize in-service training and supervision, and encourage and maintain community participation.

7. As the cornerstone of a decentralized system, district chief medical officers and their "equipe cadres" should be formally granted the necessary managerial and financial authority, with strict accountability, to supervise health care providers in implementation of integrated family planning and child health services.

4.2 Use of Nonproject Assistance

Nonproject assistance has been shown to be a useful tool for the achievement or implementation of policy and legal reforms which could not be accomplished through more traditional assistance based on direct project support. The leverage provided by NPA can strengthen the hand of a challenged Ministry in gaining support of major decision-makers and agencies for fundamental reforms.

There are, however, pitfalls inherent in supporting a program through NPA. To effectively articulate the problems that a particular program is intended to solve, and determine optimum conditions under which it should go forward, it is essential that an in-depth analysis of the policy environment be conducted in advance. In the absence of the specific objectives and detailed work plan of a more traditional project, signposts must be identified whereby progress of an NPA-assisted program can be assessed along the way. Communication among parties involved must be clear and unambiguous so that there is understanding across the board, in both the qualitative and quantitative sense, of the changes being sought.

In assessing the NHSSG, the evaluation team concluded that several factors contributed to the incomplete achievement of the goals of its NPA component:

1. Lack of GON commitment to a full analysis of the health policy environment prior to initiation of NPA activity led to an inadequate understanding of the magnitude of the policy reforms being sought.

2. The Ministry of Health and other GON officials assumed that technical assistance requirements under NPA would be less than those under traditional project assistance and were thus often unresponsive to contractors' TA inputs.

3. The "conditions precedent" originally specified for release of NPA funds were far too ambitious and complex, which caused confusion and negativism when they were not accomplished.

4. The GON had unrealistic expectations about the speed with which NPA funds would be disbursed. Consequently, they were disconcerted when planned activities to be supported by these funds could not move ahead due to delays in delivery of scheduled "tranches," resulting from under-performance.

The team concluded that further use of NPA in the Nigerien context should be very carefully considered, and only under much clearer, tighter guidelines, which are fully understood by and acceptable to the GON. Essentially, we agreed with the principal conclusion of Anne-Marie Foltz's 1994 article on nonproject assistance in Africa. Foltz writes that, for the foreseeable future, the optimum situation for use of NPA in Niger would be one in which unambiguous policy reforms have already been adopted, and the assistance would be for their implementation. Until national capacity is more fully developed and the MOH's confidence in its systems assured, it would seem that more complex applications of NPA would be a hindrance rather than a help.

RECOMMENDATION:

8. For the foreseeable future, the use of nonproject assistance in Niger should be limited to implementation of health sector policy reforms which have already been adopted by the Government, and only when particulars are understood and agreed to by all parties involved. Complex applications of NPA should be deferred in favor of more traditional forms of project support.

4.3 Resource Allocation

The NHSSG sought to promote policy reform aimed at

- Allocating a greater percentage of MOH financial resources to primary and secondary health services and other non-personnel expenditures; and

- Improving the allocation and management of human and material resources.

Toward this end, USAID proposed that data on the allocation of resources be compiled and analyzed to define the problem more clearly. Additionally, the personnel data system was to be updated and norms established for staffing of all health facilities. These criteria would then be used for the formulation of a plan for the reallocation of personnel, with priority to rural areas.

Midterm and interim evaluations of the NHSSG revealed that policy questions related to both personnel and to financial allocations had been placed on the back burner because they were considered too politically sensitive. The interim evaluation also noted that the MOH was responding to decreasing revenues by reducing non-personnel expenditures and by falling in arrears in payments for consumables. Urban-based hospitals were consuming over 50 percent of the Ministry's drug budget, and personnel costs had grown from 45 percent to 58 percent.

The evaluation concluded that economic decline and political crises were militating against the reallocation of resources and that the NHSSG had little impact in reversing resource allocation trends observed at the start of the project. This situation continued until 1993, when the new Nigerien government began a process of institutionalizing financial reforms.

4.3.1 Overall GON Budget Reforms

Recognizing that salaries consume an inordinately large portion of the national budget, the Ministry of Public Service (Ministere de la Fonction Publique) is committed to reducing personnel costs. It is doing this by reassigning large numbers of government employees from Niamey to rural areas; limiting recruitment of new employees; reducing the retirement age to 50; and reducing salaries and step increases (World Bank, May 1994 and interviews). These and other management reforms, including an improved personnel evaluation system, will be outlined in an updated version of the government's personnel manual, "Le Fonctionnaire et Sa Carriere."

The most important single reform will be the decentralization of salary administration for all government posts. According to government sources and the World Bank, which has made this a condition of its continued support, every effort is being made to put this change into effect by January 1996. Personnel recruitment, compensation, and supervision will be brought together at the district level. While this is an undoubtedly ambitious, some would say unrealistic, objective, the evaluation team feels it is worth pursuing, especially in light of the World Bank's strong endorsement. Bold measures such as this are needed to make decentralization a reality.

4.3.2 Ministry of Health Reforms

The MOH is laying its own reform foundations. With technical assistance from the NHSSG, the Directorate of Personnel and Training is establishing a comprehensive personnel database to track and monitor staff. Once the database is fully operational, the MOH will for the first time have accurate information on the size and qualifications of its staff, and, more importantly, their exact locations. This information can be used to reallocate health personnel, based on seniority, to rural areas, and thus begin to redress a situation where 80 percent of all Nigerien health personnel are located in urban areas, with only 20 percent in rural areas (1994 World Bank report).

However, discussions with the Director of Personnel indicate that lack of trained staff is compromising his ability to adequately carry out this task. Only one person in the Directorate has been trained to use the personnel database, which was installed by SNIS earlier this year, and up-to-date equipment is lacking. To effectively carry out its role, the Directorate will need infusions of new equipment and training in data entry and analysis. Such training could be performed on the job through several short-term sessions.

According to the MOH Directorate of Personnel, informal staffing standards are currently being used to plan human resource needs for district hospitals and integrated health centers. Variables considered include the type of personnel available for assignment, and the per-unit personnel needs at rural health facilities. These standards are used to assign newly graduated nurses and doctors to district hospitals and rural centers, which are generally viewed as undesirable posts. The Ministry believes that empowering departments to recruit staff and administer salaries will

enable them to make rural postings more attractive to new recruits. Closer to the action, they will be able to work with district and rural health committees to develop "in kind" incentives, such as housing and livestock.

Unless the Ministry of Public Service and the MOH work together to accomplish these reforms in a timely manner, future projects will continue to experience frequent personnel turnovers, high rates of absenteeism, and low morale. These are not attributes for creating sound decentralized health structures.

RECOMMENDATIONS:

9. The MOH should immediately update "decret 89/075," which details job descriptions for health personnel, recruitment norms, and conditions for applying for training opportunities. The decree places limitations on assignment of nurses and doctors to rural health facilities and district hospitals.

10. The MOH must establish and disseminate formal standards for hiring staff at all levels of health facilities to guide department/district planners. The national Health Development Plan suggests broad guidelines, based on a WHO model, but is not specific about the number of personnel by type of facility.

11. As noted, the World Bank is helping the MOH develop its personnel systems and norms, articulate training needs, and build its database. USAID should play a supportive role in this process, providing specific technical or program assistance as required.

4.3.3 Management of MOH Budget

The MOH has made progress in managing its budget. MOH decision-makers now have regular access to cash flow information, as well as the ability to compare planned and actual budget expenditures. This is the direct result of technical assistance provided by a regional accounting firm under a NHSSG subcontract. The financial management system developed will soon be introduced in the Departments of Dosso, Zinder, and Tahoua.

The MOH's Directorate of Administrative and Financial Affairs is producing standard monthly accounting and budget execution reports for the Minister, a "condition precedent" under the NHSSG. The budget system has become an essential element in decentralized health planning and management, and will be used to monitor cost-recovery activities. The evaluation team found the MOH's administrative staff to be confident and proud of their system and their new computer skills. The commitment of the consulting accounting firm to team building, partnership, and the non-intimidating transfer of technology was a key element in making this possible.

Finally, for the first time an inventory of all MOH property at the central level was conducted using the GESMAT software package. The inventory program is set to be implemented at regional levels, and the MOH must decide how to integrate inventory systems established by donor-supported projects into their systems.

4.3.4 Management of Local Currency Funds

The 1992 interim evaluation recommended that USAID review the structure and functioning of the Management Committee set up to administer the funds provided for subprojects under the NPA component of the NHSSG. Specifically, it found the system established by the committee for disbursement of local currency funds to be overly cumbersome. It found that the committee focused too much attention on the approval or rejection of subprojects, and spent too little time assuring the effective management of approved subprojects.

In an effort to streamline the disbursement process, in 1994 the MOH Secretary General, who is also President of the Management Committee, was given authority to countersign checks for approved subprojects. This has greatly speeded up the release of funds once they have been approved. In addition, a "Manuel des Procedures de Gestion des Fonds de Counterpartie de la SDSS," prepared by Dale Downes, an NHSSG consultant, is being finalized for use by subprojects. It provides guidelines for applying for funds and for the day-to-day management of subproject accounts. Interviews with subproject officers confirm that trial use of the manual and new disbursement procedures have led to shorter turnaround time for fund requests and less cumbersome management.

The Management Committee also needs to address internal problems which have hindered its operations. Concerns over potential conflict of interest have been raised in the case of committee members who could themselves be potential sub-grant recipients. The proposal review process has also been compromised on occasions when members have been unwilling to oppose proposals (even of poor quality) from colleagues whom they do not wish to offend.
These issues should be addressed in two ways—by making committee members ineligible to apply for subproject grants, and by asking members to recuse themselves from votes on proposals submitted by colleagues. The severity of these problems will also be reduced with expansion of the universe of potential grantees, as suggested below.

Finally, the Management Committee needs to take steps to broaden its subproject portfolio, particularly for projects that will strengthen health services at the community level. The team urges active solicitation of proposals from women's groups, religious health care providers, and other nongovernmental organizations. Retired MOH employees and recently graduated nurses and doctors could be encouraged to submit proposals. New approaches are needed to make this funding resource known throughout the country, and to encourage innovation in the provision of health services.

RECOMMENDATION:

12. The MOH's Management Committee for the local currency account should be given the budgetary support necessary for wide dissemination of the new procedures manual for proposal submission and subproject management. The Committee's management problems should be addressed, and its project portfolio expanded.

4.4 Drug Cost Containment and Management

The NHSSG was intended to promote policy reforms that would contain drug costs and improve the reliability of the drug supply system. To achieve these objectives, USAID proposed that the MOH (a) adopt a list of essential generic drugs; (b) contain costs through bulk purchasing; (c) develop a mechanism to monitor the application of essential drug policy and to assess cost savings; and (d) improve drug procurement and distribution systems.

These measures were made necessary by several factors. In 1985, 25 percent of the MOH budget was allocated for drugs, 55 percent of which were consumed by hospitals. While the MOH had essential drugs lists, it did not enforce their use, and the Office Nationale des Produits Pharmacetiques et Chimiques (ONPPC) still dealt with more than 4,000 different products. Reliance on high-cost, brand name products exacerbated the inadequacy of the MOH drug budget. Failure of the MOH to enforce essential medicines policies also contributed to high costs by permitting irrational prescriptive practices, such as poly-pharmacy and excessive use of injectables. Moreover, most health facilities experienced periodic stock outages because of the unreliability of the drug supply system.

4.4.1 Progress Toward Reform Objectives

Midterm and Interim Evaluations. The evaluations found that the MOH had prepared a list of essential medicines (EM), which was adopted in January 1989. The DEP (Direction des Études et de la Programmation) had created a database to monitor the implementation of the EM policy, but had not completed the analysis of these data. A 1991 World Bank study found that despite the policy adopted in 1989, generic drugs still constituted only 24 percent of ONPPC purchases.

While the ONPPC had plans to expand the production of generic drugs, it was unclear how such an expansion would be financed. Because of inadequate funding, the MOH was buying more drugs from ONPPC than it could afford and ONPPC in turn was falling in arrears with its suppliers. By 1993, this indebtedness precluded ONPPC from buying drugs and raw materials on the international market.

In their 1991 health sector assessment, researchers S. Fabricant and J. King provided a detailed description of the drug supply situation. They noted that chronic shortages of drugs, as well as

insufficient vehicles and personnel for drug distribution, constituted the most serious constraints to an improved drug system.

Also in 1991 the NFHDP proposed a study of the drug logistics problem, but the plan was not approved by the MOH. The NHSSG had also planned to provide TA on drug policy reform and drug distribution, but did not receive authorization to carry out this assistance.

The Situation since 1994. Two 1994 documents, Lessons Learned: USAID/Niger, 1984 to the Present, Mission Report by J.J. Frere and N. Keith and the MOH "Plan de Developpement Sanitaire 1994-2000," cited the continued lack of a reliable source of generic drugs as a major constraint to effective health services delivery.

This problem was evidenced by the need for UNICEF, through the Bamako Initiative, to create a parallel procurement system to supply facilities in Maradi. The NHSSG cost-recovery pilot test had to procure drugs directly, or through UNICEF, because of the inability of ONPPC to supply the low-cost generic drugs needed for the test. Cost-recovery experiments in Tibiri and Mirriah also experienced drug supply problems.

As recently as December 1994, the NHSSG found it necessary to provide short-term TA for the emergency procurement of drugs to ensure a continuous supply at health centers in the health districts of Say and Boboye, which participated in the cost-recovery pilot tests. The NHSSG used ONPPC as a purchasing agent with clearly defined competitive procurement procedures rather than as an autonomous supplier.

The World Bank International Development Agency Health Project also chose to use ONPPC only as a purchasing agent after experiencing difficulties with ONPPC's services as a direct supplier. To avoid such problems, Cooperation Francaise (FAC) bypassed ONPPC altogether, purchasing French franc (FF) 2 million (US$400,000) in essential drugs and medical supplies on the international market for FAC-supported hospitals and maternities.

In February 1995 a short-term technical advisor at NHSSG described the pharmacy situation in national hospitals as a "worst case scenario," with the results of reforms not yet evident. For example, the Lamorde National Hospital (HNL) had only 47 percent of recommended essential drugs in stock, only one-third of drugs requisitioned had been received, and turnaround time on requisitions was 12 weeks. Another consultant noted that 27 percent of drugs authorized by the MOH were not on the WHO Essential Drugs list, and that drugs contraindicated in the MOH Prescription Manual were still being recommended in standard treatment protocols.

This year ONPPC has used Fonds Europeene de Developpement (FED) funds to order US$6.9 million in generic drugs, which should be an adequate supply for the near future. These may be used as an initial stock for the cost-recovery program if approved by the Comite National de Generalisation. However, if these drugs are utilized before the cost-recovery program is implemented, additional subsidies will be necessary.

The FED has played a major role in providing technical and financial assistance to the ONPPC. Over CFA 3.3 billion (US$6.6 million) was provided to cover previously incurred debts that had prevented ONPPC from purchasing drugs and raw materials during 1993. The FED has provided loans for the purchase of essential medicines, along with TA in cash management, billing, and inventory control. It has also required the ONPPC to establish a separate organizational structure for the procurement of essential drugs, and set up separate accounts to monitor funds allocated for this purpose.

It remains to be seen if these efforts will be sufficient to revitalize this organization. It is the opinion of many, including the NHSSG drug logistics advisor, that the long-term solution to the drug supply problem is legislation authorizing the use of alternative supply sources.

In late 1994, the NHSSG provided TA aimed at improving drug distribution. Various configurations for the distribution network were analyzed, such as regional depots, departmental warehouses as used in the Bamako Initiative, or health district pharmacies as used by the NHSSG pilot test, as well as combinations of these approaches. Improving the drug distribution network will require the renovation of storage space, the procurement of vehicles, the provision of drug supplies for intermediate depots, staff training and additional technical assistance. The MOH has not yet acted on proposed alternatives.

Regardless of the configuration selected, the NHSSG recommended that health districts be allowed to procure drugs directly from whichever source they consider most appropriate, within MOH procurement guidelines for essential medicines. Each district could be credited with its MOH budgetary drug allocation, to be used in conjunction with funds generated through cost recovery. This approach is both flexible and fully consistent with the goal of decentralization. However, it would require developing drug procurement and management capability at the district level.

4.4.2 Conclusions

Supply problems have persisted throughout the life of the NHSSG. Until recently, the GON had demonstrated little commitment to improving the availability and use of low-cost, generic drugs. The essential medicines policy adopted in 1989 was not enforced, and the MOH continued to squander scarce resources on high-cost, brand name products and did little to curtail irrational prescriptive practices.

The recent adoption of a revised essential medicines policy and other progress during the past year would seem to reflect stronger GON commitment to the implementation of meaningful drug policy reform. However, as indicated by the Secretary General during an interview with the evaluation team, the current situation remains unsatisfactory. Coordination within the MOH is inadequate, and ensuring availability of generic drugs in the health centers is still a problem.

Continued technical and financial assistance from USAID and/or other donors will be necessary to improve this situation.

In the long run, liberalizing drug importation, that is, breaking the ONPPC monopoly and thereby eliminating the risks associated with sole source procurement, may be the most effective solution. There is an inherent conflict of interest in the current system in which ONPPC retail pharmacies compete with health facilities for which it is the wholesale supplier, and problems will persist until this conflict is removed.

It is too early to assess the outcome of TA recently provided by the FED and the NHSSG. The rationalization of drug procurement has just been initiated and additional assistance in drug management is required at all levels. Moreover, the MOH must resolve the clinical issues briefly mentioned above, ensure consistency between authorized drugs and treatment protocols, and reinforce practices through improved training and systematic supervision.

RECOMMENDATION:

13. USAID should work more closely with other donors, especially the FED, in encouraging and supporting improvements in MOH drug distribution infrastructure and operations. Continued TA should also be provided through the new project to improve procurement, inventory control, and distribution consistent with the goals of decentralization, especially at the district level.

4.5 Hospital Cost Containment and Cost Recovery

The NHSSG was designed to foster policy reform aimed at containing unit costs in hospital services, so as to make more efficient use of available resources and enhance the sustainability of public health services.

A number of conditions prompted policy reform in the hospital sector. In the mid-1980s, hospitals, accessible to 15-20 percent of the population, accounted for about half of the MOH operating budget. With budgets skewed in favor of hospitals, there was no mechanism to examine the recurrent cost implications of donor funded investments in the hospital sector. A cost-recovery system of sorts had been operational since being enacted by the legislature in 1962. But it was not rigorously enforced, and it generated funds equivalent to less than 5 percent of operating costs. A modified fee structure had been proposed in 1984, but was never implemented. Furthermore, there was little incentive to collect fees, since they reverted to the general treasury.

To achieve reform, USAID proposed that (a) a report be prepared showing hospital collections in accordance with the 1962 legislation; (b) patient registration and fee collection systems be analyzed and recommendations made to improve patient reception facilities and systems; and (c)

an accounting system be developed for Niamey National Hospital to permit the analysis of all operational costs, and to facilitate the evaluation of cost recovery and resource allocation objectives.

4.5.1 Early Progress Toward Reform Objectives

Midterm and Interim Evaluations. The 1989 evaluation found that proposed hospital renovations had been delayed, but that numerous studies of hospital operations, including patient registration and triage, revenue collection, accounting systems, and cost analysis were under way. Because of delays experienced by the World Bank in conducting its own series of hospital studies, these too were shifted to the NHSSG.

The studies indicated, among other things, that the hospital share of the MOH operational budget had increased from 50 percent in 1980 to 58 percent in 1990, while the drug share of the budget had declined by nearly 40 percent. During this period the MOH had also become increasingly dependent upon foreign assistance to finance nonhospital services.

The 1992 evaluation observed that while the hospital studies had been carried out, the MOH had not implemented recommendations and there were no plans to carry out proposed policy and institutional reforms. A new hospital accounting system had been designed and staff trained in its use, but the system had never been installed. The lack of timely, accurate financial data remained a significant obstacle to sound hospital management.

On a more positive note, a workshop was held to discuss the conversion of the three national hospitals in Niger into parastatal organizations. There had also been a slight increase in hospital collections, from 4 percent to 7 percent of operating costs.

The 1992 evaluation team concluded that the lack of progress in hospital sector policy reform was in part attributable to the adoption of benchmarks based on the completion of studies rather than actual implementation of proposed reforms.

4.5.2 Progress since 1992

Hospital studies did prove of value, however, and were used by USAID, the FED, and the FAC to lay the groundwork for the 1992 enactment of legislation converting the three "national hospitals" (Niamey National Hospital [HNN], Lamorde National Hospital [HNL], and Zinder National Hospital [HNZ]) into semiautonomous public administration entities, or EPAs.

Between 1992 and 1995 NHSSG provided long-term technical assistance and funding to support the MOH in the implementation of hospital reforms. NHSSG activities and accomplishments, as

observed in the field and as described by contractor personnel, technical consultants, and the directors of the national hospitals, are summarized below.

Reform activities completed include

Work Plans for Hospital Sector Reform. Assistance was given for the development of a framework for continuation of hospital sector reform over the next two years. It is assumed that the financing and implementation of reform activities would be coordinated with the FED and the FAC.

Conversion to EPA. The NHSSG assisted the three national hospitals in the implementation of the EPA statute, in defining the roles and responsibilities of the hospitals, and in the initiation of governance and management committees. TA was also provided in the preparation of the legal framework for the conversion of five departmental hospitals into EPAs. The MOH still needs assistance in improving the quality of hospital governance and management in order to achieve the gains made possible by EPA status.

Remodeling. The grant provided TA and funding for remodeling at the three hospitals, which permitted the installation of improved patient registration systems, as well as renovation of the medical unit at HNN and the surgical unit at HNZ.

Hospital Organization. Project technical advisors assisted management staff in the development of hospital organization charts and job descriptions for key hospital personnel. These measures were intended to clarify roles and responsibilities within the hospital and to contribute to the rationalization of hospital management.

Patient Registration Systems. The contractor assisted in the development and implementation of improved patient registration systems at the three national hospitals.

Reform activities initiated, but not expected to be completed by the end of NHSSG, include

Pharmacy Management. TA was provided for the establishment of pharmacy baseline indicators and the formulation of plans to improve pharmacy management. The provision of emergency drug stocks by the FED has temporarily improved conditions, and one of the national hospitals, HNL, has resorted to rationing drugs, thus limiting the amount of medications being prescribed in order to extend the available supply. The MOH has yet to implement plans proposed by NHSSG to improve drug management in the national hospitals.

Personnel Management. A study of changes needed to delegate personnel management authority to the national hospitals has been completed and recommendations made, including a proposal for enabling legislation. However, this has not yet been enacted and it is unclear whether the GON is prepared to implement the extensive and complex changes necessary to permit this delegation of authority. In the opinion of the NHSSG contractor, this is an unrealistic objective. Yet, without

such a delegation of authority, the national hospitals will remain semiautonomous in name only, since their managers have no control over personnel appointments, terminations, transfers, or even shift assignments.

Financial Management and Cost Recovery. The NHSSG technical advisor assisted in the preparation of the 1993-1995 budgets for the national hospitals and in increasing hospital collections through more effective use of existing systems. The improvement in hospital collections is shown below:

Table 1

RECEIPTS (CFA 1,000,000) INCREASE

HOSPITAL	**1992**	**1994**	**% Increase**
Niamey National Hospital	88.6	92.8	5%
Zinder National Hospital	11.0	23.1	110%
Lamorde National Hospital	24.2	27.5	5%

It is unfortunate that the impact of this improvement in collections has been offset by the devaluation of the CFA.

The NHSSG recommended revision of fee schedules which have been in effect since 1962, and new fees are now being adopted. While the new fee schedule should result in improved collections, these revenues will cover only a small portion of operating costs. NHSSG staff also developed a scope of work for the recently installed general accounting system at the national hospitals. Hospital directors advised the evaluation team that staff required to manage the new system had not yet been allocated by the MOH.

4.5.3 Conclusions

Progress in reforms in the hospital sector since the start of the NHSSG has been uneven. The TA team completed several studies early in the grant, but the MOH did not implement recommended reforms. Progress has been steadier over the last two years. The national hospitals have been converted into EPAs. Other reforms were recently implemented and need continued support. New financial management systems are currently being implemented.

Groundwork for crucial reforms in personnel and pharmacy management has been completed, but the MOH has yet to carry them out and may not be able to do so without continued technical and

financial assistance. Such reforms are complex, and the issues they present may not be resolved in the near future.

According to the principal NHSSG contractor, it is unlikely that the hospital sector will consume a decreasing share of the MOH budget in the future because of a growing tertiary care caseload. A more realistic objective would be simply preventing a further increase in the hospital share. This opinion is at variance with that of the NHSSG hospital management advisor, who indicated that hospital cost-recovery reform "should permit the MOH to reduce the proportion of national budget expenditures in favor of the nonhospital sector." While cost-based pricing and health insurance have been used to resolve this dilemma in other countries, it is doubtful if Niger is ready to adopt these approaches.

Finally, the increased use of generic drugs will contribute to cost containment, but the MOH must eliminate unnecessary duplication of services between the two national hospitals in Niamey (HNN and HNL), as well as reduce the inappropriate use of these facilities for primary care.

While TA provided under the NHSSG since 1992 has been effective, management system improvements recently implemented or in process still are fragile. Limited MOH absorptive capacity necessitates continued technical support to ensure that progress achieved to date is not lost.

RECOMMENDATION:

14. USAID should provide short-term TA through the new project to help the MOH complete reform measures already initiated in pharmacy management, personnel management, financial management, and cost recovery at the national hospitals, and to assist the MOH in conversion of departmental hospitals into EPAs.

4.6 Nonhospital Cost Recovery

A principal NHSSG policy objective was to increase cost recovery, and thus improve sustainability in public sector health services other than hospitals. The grant was to fund studies of alternative cost-recovery mechanisms and assist the MOH in implementing cost-recovery activities based on analysis of the studies.

The conditions prompting nonhospital, cost-recovery policy reform were numerous and well documented. Access to health services was among the poorest in Africa. Yet, with its over-emphasis on tertiary care, there was no flexibility within the central MOH budget that would permit broader coverage. In addition, the drug budget was inadequate, as evidenced by periodic shortages and outages throughout the system, especially in rural areas.

On the other hand, health care financing studies in 1985 and 1986 had shown that the population was willing to pay for health services. And the World Bank's Structural Adjustment program contained a precondition that the MOH conduct a study of cost-recovery measures aimed at increasing funding for primary health care.

4.6.1 Progress Toward Reform Objectives

Midterm and Interim Evaluations. In order to meet NHSSG preconditions, the contractor proposed a number of pilot tests of different cost-recovery mechanisms during the first years of the project, but encountered difficulty in getting MOH/DEP approval. In January 1992, over five years after the start of the NHSSG, the MOH finally accepted a design for a pilot test first proposed in 1990. The World Bank pledged US$500,000 to finance initial drug supplies for the test, with other funding to be provided by USAID.

The 1992 evaluation also discussed a number of cost-recovery issues, which still have not been fully resolved. These included the need to enact legal texts permitting nonhospital cost recovery, the lack of a reliable supply of low-cost generic drugs, the need to establish cost-based fees with specific revenue targets, relative pricing for different levels of health care, and the need for a plan to phase in cost recovery throughout the system.

Cost-Recovery Initiatives at Tibiri and Mirriah. Between 1986 and 1990 the FED conducted a test of nonhospital cost recovery using an indirect payment mechanism in the district of Mirriah, which in 1990 had a population of 457,000. Only 20 percent of this population lived within five kilometers of one of the fourteen health facilities involved in the test. A surtax was set at CFA 100. (A nominal co-payment had been planned, but it was never put into effect.) Utilization peaked in 1989-1990 at an annual rate of 0.45, comparable to what was later observed in Boboye. Over the 1987-1990 test period, revenues covered 86 percent of actual drug costs and 53 percent of total costs.

In 1989-1990, Belgian Cooperation conducted cost-recovery tests using the direct payment method in the canton of Tibiri located in the department of Dosso. The study involved a single rural dispensary serving a total population of 93,000 of which 15,000 lived within 5 kilometers of the facility.

Initial fees were set at CFA 200 for adults and CFA 100 for children, but these were found to be inadequate and subsequently doubled. Significantly, nearly 90 percent of the caseload came from the village of Tibiri, which accounted for less than 10 percent of the canton's population, indicating that most of the population had poor access to care. Average cost per new case was CFA 330. Revenues for the year covered 53 percent of drug costs and 40 percent of total costs.

The cost-recovery pilot tests in Tibiri and Mirriah were relevant to the NHSSG because they demonstrated that, within limits, people are willing to pay for health care. While the indirect

payment method was more effective in generating revenues given the surtax and fees used, it raised serious equity issues over inequalities in access to care. Despite the information provided by these experiences, the MOH concluded that additional tests were required before launching a national cost-recovery effort.

Bamako Initiative. Since January 1994, UNICEF has been involved in the implementation of the Bamako Initiative in the department of Maradi. The program is being extended into 48 health centers covering a population of approximately 1.8 million. UNICEF provided an initial stock of drugs to cover estimated first year needs, but subsequently had to increase this allocation by 50 percent because of delays in increasing fees after devaluation.

During 1994, health centers recovered 45 percent-65 percent of operating costs. Fees were initially set at CFA 300 for adults and CFA 150 for children, but these were doubled in January 1995 to cover increased costs associated with the 50 percent devaluation of the CFA. According to UNICEF, political turmoil, delays, and community objections to the fee increase could have been avoided if the MOH had accepted the fee schedule originally proposed. UNICEF has expressed concern over the sustainability of Bamako Initiative activities in Niger since the current fee schedule does not generate sufficient funds to cover total operating costs.

In the past year the NHSSG contractor has placed a priority on standardizing the Bamako Initiative and cost-recovery pilot test systems, which will be used in the extension of cost recovery nationwide, and has also provided TA in the analysis of Bamako Initiative utilization, cost, and revenue data.

The NHSSG Nonhospital Cost-recovery Pilot Test. Between 1992 and 1994, the NHSSG conducted its own cost-recovery pilot test in the districts of Say, Boboye, and Illela to obtain information on the relative advantages of alternative cost-recovery mechanisms. A direct payment system was utilized in Say, with fees of CFA 200 per new case for persons five years of age and older and CFA 100 per new case for children under five. In Boboye, a combination of indirect payments and fees was evaluated. A surtax of CFA 200 was added to the arrondissement head tax, accompanied by a co-payment of CFA 50 per new case for those five and older and CFA 25 for those under five. Illela served as a control site.

The two study areas were deemed to be roughly comparable. Boboye, with a population of 250,000, has 20 percent more people than Say and two more health facilities. Access to health care is a problem in both areas, with less than one-fourth of the population residing within five kilometers of a facility.

Revenues obtained in Boboye covered 147 percent of drug costs and 87 percent of total costs, while Say recovered 52 percent of drug costs and 35 percent of total costs. The analysis of pilot results also revealed that drug costs per new case of CFA 277 in Say were over two and one-half times those observed in Boboye. This difference was attributed to the fact that health providers in Boboye had been trained in the use of standard treatment protocols and prescriptive guidelines

(SPT) while personnel in Say had not received such training. This finding illustrates the importance of SPT training to the success of cost-recovery activities in Niger.

The data compiled during the pilot test also provided the basis for examining what would have been the outcome of the study had Say been selected as the site for indirect cost recovery rather than Boboye. In this instance, 135 percent of drug costs and 59 percent of total costs would have been recovered through the direct method in Boboye, while only 58 percent of drug costs and 47 percent of total costs would have been recovered under the indirect method in Say.

These calculations imply that the results of the pilot test were attributable to differences in average drug costs between the two sites and not to the cost-recovery method. The study outcome was also predetermined by the choice of fee structures. The surtax applied in Boboye was identical to that used in Mirriah. However, it was obviously impossible for the direct payment mechanism in Say to achieve breakeven with average drug costs of CFA 277 and fees of CFA 100-200, which was half the price level used in Tibiri four years earlier.

The test raised the same issues observed in Tibiri and Mirriah. Specifically, the direct fees appear to pose a greater financial barrier to the lowest income groups, but in the indirect payment system, the population residing more than five kilometers from a facility subsidize the care of those with better access. The indirect payment system is also susceptible to exploitation by individuals living outside the health district while flat fees discourage utilization for "low cost" ailments. Additionally, as noted by the medecin-chef of Boboye, there is a need to ensure that funds generated through the surtax are in fact made available to the health district for the purchase of drugs.

While the validity of this pilot test activity may be open to question, it nevertheless had a significant and positive political consequence. After reviewing study results, the MOH decided to launch a national nonhospital, cost-recovery program. Additionally, it agreed to give each district the choice of cost-recovery mechanism, rather than impose a single system upon the entire country.

It is important to note, however, that while the pilot test showed that it is feasible to generate funds through cost recovery, it did not demonstrate how the MOH and rural communities would jointly manage revolving drug funds, since available funds have yet to be used to purchase drugs and pay administrative costs. The sustainability of this approach has yet to be proven in Niger.

Progress since 1994. The NHSSG nonhospital, cost-recovery, 1994-1995 work plan and, implicitly, that of the GON with respect to this activity, included three major elements. The contractor was to assist the MOH in (a) the formulation of a legal framework for nonhospital cost recovery; (b) the continuation of cost-recovery activities in the pilot test areas; and (c) the progressive implementation of the national nonhospital, cost-recovery program.

The political turmoil experienced during 1994-1995, including the dissolution of the National Assembly, precluded the enactment of a legal framework for the implementation of the cost-recovery program until recently. But the need for such legislation has been recognized, at least since the initiation of the NHSSG, and was specifically mentioned as an unresolved issue by Foltz in the 1992 NHSSG evaluation.

During the past year, the NHSSG contractor provided short-term TA to the GON in the formulation of enabling legislation and implementing regulations (decree and arrete) for nonhospital cost recovery, on the computation of cost-based fee schedules and on the exploration of alternative configurations for a drug distribution network. The Comite de Generalisation has yet to act on the recommendations regarding fee schedules.

The NHSSG sponsored a national cost-recovery workshop in July 1994 to discuss the results of the pilot test and to set the stage for the implementation of the national program. However, it proved necessary to hold these plans in abeyance because of the failure of the GON to enact enabling legislation on a timely basis.

NHSSG and BCS staff provided little or no technical supervision to the Say and Boboye health districts between the end of the pilot test and June 1995. Moreover, health facilities received little supervision by district personnel during this period, resulting in serious management problems. These included poor documentation of patient visits and fee collections, misuse and disappearance of funds, and drug outages requiring emergency procurement by the NHSSG.

In retrospect, the pilot test was perceived more as an economic experiment than as a laboratory for the development of systems for decentralized health services delivery and nonhospital cost recovery. As outlined below, existing systems such as structures, policies, and procedures, were found to be inadequate for effective implementation of broad cost-recovery initiatives.

Drug Management System. While progress has been made in rationalizing drug procurement, the MOH has yet to respond to NHSSG recommendations for improving the drug distribution system. During the past year, the pilot test zones experienced periodic drug outages and were still partially dependent on the NHSSG for drug supplies.

Prescriptive Practices. Reducing average drug costs through Strategie Plainte-Traitement (SPT) training, as demonstrated in Boboye, is critical to the success of the cost-recovery program. However, the MOH has only recently began to train health providers in the use of these methodologies.

Financial Management Systems. Standardized financial management systems being developed by the NHSSG for the national cost-recovery program have yet to be finalized. Experience in other countries has shown that such systems should be as simple as possible, consistent with generally accepted accounting principles. To date, the NHSSG has provided drugs and has financed cost-recovery activities. But the ability of the MOH and local health committees to manage revolving

funds for drug procurement has yet to be demonstrated, and it remains unclear how the committees will gain access to funds generated through the surtax.

Management Information System. Once pilot test data were collected, monitoring of health centers in the pilot test zone essentially came to a halt. There currently exists no system to collect and analyze facility-specific data on revenues, costs, and drug consumption on a regular basis to identify problems promptly and facilitate timely corrective action. Close monitoring of revolving drug funds is critical, especially during early operational stages when problems frequently occur.

Cost-based Pricing. Bamako Initiative sites doubled their fees in January 1995. In contrast, pilot test sites are still using their original fee schedules and incurring deficits 18 months after the devaluation of the CFA. Moreover, the surtax in Boboye was discontinued after the completion of the pilot test period. NHSSG studies indicate that pilot test sites would have to increase fees by a factor of 3-4 to achieve breakeven, and it is unclear how the population would react to such an increase. However, unless new fees are adopted promptly, funds generated will remain insufficient to replace drug stocks and additional subsidies will be required.

Supervision. The NHSSG and the MOH have failed to provide regular, systematic supervision essential to the survival and effectiveness of cost-recovery efforts. Lapses as occurred during the past year could result in the failure of revolving funds, which depend on the sound management of fee-generated revenues for their operation.

Program Implementation. Discussions with BCS personnel revealed the lack of a well developed strategy for progressive implementation of the cost-recovery program, due in part to internal MOH coordination problems. Unless cost recovery is implemented in phases, with close supervision and coordination during early operational stages, resulting problems could overwhelm technical and management support systems.

4.6.2 Conclusions

In 1992, Foltz et al. summarized NHSSG progress in pursuing cost-recovery policy reform as follows: "The cost-recovery reforms in nonhospitals, even though they were only pilot tests, were, during the last five years, debated, approved, set aside, delayed, debated, included, excluded, and eventually included in the policy debate...In retrospect, this history does not show much commitment to cost recovery at the highest levels of government." While the situation has improved somewhat in the last four years, nonhospital cost-recovery efforts continue to experience persistent delays, as they have since the start of the NHSSG.

The nonhospital cost-recovery pilot test was not initiated until the fifth year of the grant and was not completed until the spring of 1994. While the validity of conclusions derived from the pilot test is open to question as discussed above, the test had important political consequences, motivating the MOH to launch a national cost-recovery program.

According to the NHSSG's long-term technical advisor, numerous factors, including political turmoil, strikes, the dissolution of the National Assembly, and the failure of the Comite de Generalisation to meet have militated against the achievement of greater progress during the past year. However, the effectiveness of NHSSG technical assistance must also be questioned. The Quality Assurance Project in Tahoua and the Bamako Initiative in Maradi managed to progress satisfactorily under the same institutional and political conditions.

Significant progress has been made in improving the drug supply system, developing a standard financial management system, and setting up cost-based pricing. The MOH has adopted an essential medicines policy and has initiated SPT training. However, the MOH must still develop a management information system and a supervision methodology, as well as formulate an implementation strategy, before it can successfully extend nonhospital cost recovery on a nationwide basis. Certainly, the Ministry's approach to these tasks will demonstrate whether it is committed to cost recovery. At the same time it is clear that, without continued technical and financial support, even progress achieved thus far may never be institutionalized.

RECOMMENDATION:

15. Given a clear commitment on the part of the MOH to the urgent implementation of a national cost-recovery program, USAID should, through the new project, continue providing training and technical assistance in development of drug management systems, financial management systems, management information systems, and supervision procedures required to make this possible.

4.7 National Health Information System (SNIS)

Establishing the SNIS was a time consuming educational process. The strategy included training in the use of word processing and spreadsheet software (WordPerfect and LOTUS) for the staff of MOH Directorates, who were also trained in routine maintenance of computers. As managers began to appreciate improvements in the quality of documents produced by their staffs, they also became interested in further utilization of computers. This opened the door for SNIS to set up, with the collaboration of the Ministry's senior management, the various forms for data collection required to meet the program's priorities.

Through its departmental epidemiological surveillance center (CSE), SNIS produces and disseminates liaison bulletins such as "Arewa Sante" and "Sante Info," and monthly disease status reports (MDO Bulletin). According to the SNIS acting director, this routine surveillance and reporting leads to preparedness. Indeed, SNIS gave an early and impressive demonstration of its usefulness in the early detection of the meningitis epidemic, prevention of its expansion, and timely mobilization of resources.

Except for designing district health plans, use of available data for decision making has so far been limited. However, gradual progress is occurring here as well, and SNIS is beginning to systematize its data gathering and publication schedules. For example, annual activities at the central level now include the issuing of Annual Statistics in October, review of data collection forms in November, and diffusion of any revised forms for the coming year by December. SNIS is considering ways to contract its services to international organizations working in Niger, and it has also established formal collaboration with WHO Geneva for operations research, with Laval University in Quebec, and with UNICEF.

In general, Niger's National Health Information System is off to a good start, but it will also require continued support and technical assistance. Needs specified by central staff include:

- Further study of the meningitis epidemic, and in-country training in operations research.
- Workshops on the maintenance of computer systems to upgrade and maintain existing skills.
- Strengthening of back-up systems.
- Training of additional resource persons to ensure the sustainability of the system.
- Installation of local area networks, for the purpose of information sharing and distance learning. VITASAT might be interested to experiment.

RECOMMENDATIONS:

16. Technical assistance for the SNIS should be maintained, drawing on international experience, especially in disease surveillance and operations research. The goal should be effective utilization of information at district levels, full integration of a national system, and long-term sustainability.

17. In response to the MOH's clear commitment to SNIS and to staff proficiency in its use, the new project should include in-country, short-term courses for SNIS personnel in the development and maintenance of computer systems. It should also train MOH teams to provide regular TA and maintenance to systems at regional and district levels.

5. THE NFHDP: SUCCESSES, FAILURES, AND IMPLICATIONS FOR THE FUTURE

5.1 Expansion and Strengthening of Family Planning Services

5.1.1 Availability

In light of its stated purpose to "strengthen the capacity of Nigerien institutions to plan, support, and monitor family health services on a national basis," it can be said that the NFHDP has made important progress in a short time. This is especially true in comparison with other countries in the region (for example, Cote d'Ivoire, Burkina Faso), most of whom have had at least two decades of family planning experience and yet are not significantly more advanced than Niger in acceptance levels or coverage.

Availability and utilization of maternal and child health (MCH) and family planning services at all levels is now a reality in Niger, as is a general awareness of the existence of modern contraception. Furthermore, contraceptive services have been treated as an integral part of overall family health services as the MOH has developed its plans and tested various models of decentralization.

5.1.2 Service Quality

Nevertheless, the quality of services must be greatly improved. While contraceptives are indeed available at all levels of the health system, the evaluation team found serious deficiencies in the overall quality of family planning services. This had the effect of limiting their accessibility almost as much as if the devices themselves were not available. Areas of less than acceptable quality included

Poor Reception. Women coming to health facilities, often from a long distance, to request contraceptive services complained about being made to wait for long periods before seeing a health worker, and then being treated abruptly or with a pronounced lack of sensitivity to their concerns. Such attitudinal obstacles can have a distinctly de-motivating effect.

Inflexible Schedules. Too often, women presenting for services are told that the services are not available at that time or on that day. Again, often the women may have walked a long distance to get to a facility and may be too discouraged or busy to come back.

Lack of Proper Integration of Services. In many health facilities visited, family planning was still not fully integrated into overall family health services despite national directives and guidelines to this effect. Either family planning (FP) was not routinely available, or it was delegated to

personnel with other responsibilities, such as midwives who are normally busy attending deliveries.

Lack of Training. Many health care providers whom the team interviewed were unaware of or inadequately trained for their responsibilities as family planning service providers. Lack of interpersonal and communications skills also contributed to negative attitudes towards clients. On-the-job training appeared nonexistent, and supervision of family planning workers, especially in peripheral areas, was clearly inadequate.

Sanitation. Many health facilities exhibited disappointingly substandard levels of cleanliness and sanitary practice. While lack of training and supplies can explain this to some extent, it also showed a need for a greater effort to establish, institutionalize, and monitor standards for proper levels of sanitation at the different service levels.

5.1.3 Conclusions

Although commendable progress has been made under the NFHDP in terms of "putting family planning on the map" as a full part of decentralized and integrated family health services, much needs to be done to make FP services truly accessible, responsive, and of acceptable quality. The new project should make quality of care a high priority. Results of operations research activities, such as those contained in the Quality Assurance Project, will be instructive in achieving this objective.

RECOMMENDATIONS:

18. The Ministry of Health must express its clear commitment to improving the quality of family planning/MCH services by upgrading service skills, changing attitudes of health care workers towards their clients, and updating service and sanitation standards. A two-day national workshop is proposed to sensitize health workers at all levels to their roles and responsibilities in this area. Such an approach has met with success in a similar situation in Mali.

19. Supervision at all levels of the health system and training in supervisory techniques are presently weak, especially in family planning service delivery. A priority under the new project should be training for supervision at district and subdistrict levels.

5.2 Training

5.2.1 Activities to Date

The NFHDP (as well as the NHSSG) has supported training activities in Niger, other countries of West Africa, and the United States. Many of these training inputs, whether in information technology, management, IEC, basic research, or other areas, are discussed in different sections of this report.

Six senior staff (all male) obtained master's degrees in management, health economics, health financing, and epidemiology from U.S. universities. They are now working for the MOH or donors collaborating with the Ministry in areas related to policy reform. Forty-six individuals participated in seminars in the United States or the Africa region. Both projects provided short-term training through in-country seminars and workshops.

The evaluation team found training-of-trainers manuals and curricula focusing on health center management, family planning, child survival interventions and immunization. Remnants of a national training-of-trainers team, not presently functional, were found at the Ecole Nationale de Sante Publique and the Directorate of Training. We also found that training has began in elements (for example, developing plans, supervision) of the district health approach. Departmental personnel are currently developing district training plans, which will be funded through the local currency account.

The team was, however, not able to get an effective overall picture of current training resources and activities in Niger, which hindered the team's ability to provide an inclusive assessment. We recommend an early effort to assemble an inventory of all past and current training resources and programs, which would provide an excellent tool and guidepost for the near future. It would enable the MOH and the new project to have a complete picture both of what is available and where the major gaps exist.

5.2.2 Future Training Needs

While the National Health Plan, 1994-2000 ("Plan de Developpement Sanitaire"), provides some elements of the MOH's training goals in a decentralized, district-based program, an overall strategy for achieving results was not found. To help in its development, and to identify specific related training needs, a study tour to a neighboring country with a functioning decentralized district approach would be an instructive point of departure. The inventory suggested above would also contribute to this process.

Near term training gaps that need to be filled will certainly include, (a) management training for district health teams, covering management of human resources, management of vehicles and other equipment, supervision and evaluation; (b) training in drug supply management and cost recovery; (c) team building; and (d) problem solving. Community health committees, selected democratically, should receive training for their role as managers of health facilities and funds. In

all cases, experience has shown that formal workshops or courses must be supplemented by on-the-job training, if long-term impact is to be assured.

With specific reference to preservice training, an outline of reproductive health training curricula, developed with Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) assistance, was approved by the MOH in July 1995. It is already intended for these curricula to be integrated into existing nursing and medical school curricula starting with the 1995-96 school year.

RECOMMENDATION:

20. Numerous training interventions will be required to make possible the successful implementation of a national, decentralized primary health care strategy. The new project should be prepared to provide these interventions, starting with the preparation of a detailed inventory of training resources available in Niger, as described above.

5.3 Information, Education, and Communication

5.3.1 The Past

The importance of a well-planned IEC/health education component to Nigerien health programs cannot be overstated. Yet after seven years of the NFHDP and other health and nutrition projects, IEC resources of the MOH cannot meet its needs. Past experience has not resulted in an IEC capability to respond effectively to demands of health facilities for informational and motivational inputs that will change health behaviors. There is, in effect, no health education program that systematically supports the achievement of national health objectives. According to Frere and Keith in Lessons Learned: USAID/Niger 1984 to the Present, Mission Report, Draft May 1994, "Health education in Niger remains a minor concern in most MOH organized training, with no hands-on practice of skills, and no provision for follow-up and improvement."

Changing health and nutrition practices requires the ability to develop psychological and educational strategies appropriate to the cultural and political contexts of specific parts of the country. This in turn requires an ability to analyze demographic and behavioral information on target groups before designing the strategies that will motivate and sustain new health behaviors.

Yet IEC activities in Niger have focused on undifferentiated audiovisual products, brochures, occasional radio spots, and didactic "causeries." Methods that rarely motivate change. Evaluations of health education programs throughout the world point to health service providers, family, friends, and the mass media as the most influential sources of information about health issues, and group pressure as the key to changing health practices.

5.3.2 The Present

It is clear that the move towards decentralization and the growing pressure to improve service delivery while reducing costs require a new and more substantial investment in the development of professional IEC/health education skills and products. Nigeriens responsible for IEC in the various health services agree with this. At the same time they feel strongly that the NFHDP has not adequately respected, nor effectively maximized, their abilities and ideas.

The last IEC advisor to the project faced hostility and conflict from Nigerien counterparts, which, together with the 1994 strikes, brought the IEC program to an impasse. The team was not given a full picture of the reasons behind the conflict, nor did it think this was necessary. What is important is that, while acknowledging the need for outside technical assistance, MOH IEC specialists want to feel responsible for their own program, and to be able to draw first and foremost on Nigerien, or other African, IEC expertise. An understanding of and respect for this desire on the part of future contractors will be important to maximizing the benefits of technical assistance, not only for IEC but in all areas of program activity.

5.3.3 Field Experiences

IEC services have historically been delivered, like other health services, through a "cascade system," moving down from department to district levels and, through various outreach strategies, to "quartiers" in towns and villages. But while health service providers at different points of the cascade get some introduction to IEC, it is rarely enough to enable them to effect health-related behavior change. Nor do they have the time.

Potentially, the most important part of the cascade are the "Antennes Régionale d'Education pour la Santé" (ARIEPS), field personnel who, along with their subregional counterparts, are responsible for decentralized, local IEC activities. But the numbers of ARIEPS are small and their training inadequate for their dual roles of program implementation and training of outreach agents. Other outreach programs promoting family health and family planning, such as those of the Centre Nationale de Santé Réproductive (CNSR), depend on various kinds of unpaid, largely untrained community workers, such as "secouristes" and "matrones," and have had uneven success at best.

5.3.4 Ministry Structures

The MOH plans to regroup the health and family planning IEC staffs of the various health services into one IEC/health education unit, as was the case in 1987. This will be an important unifying step, one which should take place as soon as possible. The Ministry can then proceed to integrate IEC services into a coherent whole.

The IEC Unit in the MOH alone now includes nine people with the equivalent of master's degrees in health education, psychology, and/or sociology from African and European universities. In an informal consultative meeting with the evaluation team, the group communicated its strong interest in playing an active role in planning and implementing the IEC component of the new NPHSS project. They plan to present a one-to-five year plan for IEC needs and programs shortly, one which emphasizes a community-based, community-oriented approach to health and family planning IEC.

RECOMMENDATIONS:

21. Under the NPHSS (the new project), the IEC unit of the Ministry of Health should be transformed through training and technical assistance into an agency fully capable of planning, implementing, and evaluating health information and behavior change campaigns at all levels.

22. The new project should provide the MOH with a long-term health education/IEC advisor, preferably a Nigerien or French-speaking African. The advisor will be responsible for developing an effective collaborative partnership with the IEC unit, and providing whatever services are required to fully professionalize the Unit.

5.3.5 Personnel and Training Requirements

The key element in the new IEC approach will be personnel. The MOH must add more regional and local IEC agents to cover key districts, rather than depending on health service providers for health education. The latter have neither the time nor training for this. The development of regional and local IEC capability will require priority attention under the new project.

As discussed between the evaluation team and MOH IEC personnel, to sustain a community-based health education program they first require training in

- Elements of IEC/health education information and behavior change campaigns
- Planning, implementing, and managing such campaigns
- Community research and evaluation methodologies
- Behavior change strategies
- Audiovisual material design, testing, and production
- Small group and interpersonal communications
- Sustaining new behaviors
- Background in family health, family planning, and AIDS

While occasional short-term technical assistance in these areas may be needed, a carefully planned, behavior change-oriented training program should eliminate the need for most ad hoc seminars and workshops, which are largely ineffectual while taking participants away from their

field work. Given the high interest level of IEC personnel in the MOH and other services, a training program designed within the time frame and context of the new project will create a competent core of experts.

(One area in which IEC workers should not be expected to involve themselves is counseling. IEC personnel are often asked for clinical family planning advice, or expected to train local health providers as counselors. Counseling responsibilities should be specifically assigned to properly trained service providers, leaving IEC personnel free to focus on their educational roles.)

RECOMMENDATIONS:

23. To achieve the desired levels of professionalism on the MOH IEC team, a United States university with a strong behavior change-oriented health education program should be contracted to provide three in-country, for-credit courses each year for two years. These would be designed for health and family planning IEC specialists in the MOH and NGOs. Advanced training for selected personnel could be provided as appropriate.

24. IEC training should be developed for community health clubs, "leaders d'opinion," and other community agents. Focus would be on community research and the planning of communication strategies based on findings. The new project should also test models for motivating community workers by linking their work to modest income generation.

5.3.6 Logistics and Materials Development

IEC specialists also stressed the need for adequate logistical support, especially for transportation in connection with training, supervision, and technical assistance. Only twice since it was founded has the IEC Unit in the MOH been able to do effective field supervision due to the lack of such resources. The Unit will describe its logistical needs in the five-year plan it will send to USAID for the NPHSS.

It is important to emphasize that materials development is typically given far too much weight in IEC programs. Costly to produce, and of limited effectiveness by themselves in changing behavior, IEC materials must be conceived as part of a carefully researched information/communication strategy, rather than responding to a conventional desire for print and audiovisual products. At this point a range of materials already exists in Niger, and can be used as appropriate. Development of new materials should await the completion of such a strategy. An investment now in adequate logistical support will pay great short-term dividends.

5.3.7 Donor Support

International donors contributing to IEC activities in Niger have often supported conflicting IEC agendas, or nonessential or outmoded programs. Although with the best of intentions, donors have tended to respond in an uncoordinated manner to requests, either from government agencies or NGOs that are unrelated to any coherent IEC strategy.

Under the NPHSS it will be critical for all donors interested in IEC to "speak from the same page." By working through the project in a coordinated partnership with the MOH IEC team, funders can have a hand in developing the rationale behind Nigerien health education strategies, and be able to make more informed decisions on those which merit support.

5.3.8 Comments on the IEC Portion of the NPHSS Request For Proposal

The section establishing requirements for the IEC component stresses preparation of audiovisual materials and stocking district reference libraries with IEC materials. For reasons noted above, this could be relatively ineffective compared to investment in training of IEC agents in the development of community-based programs to promote new health behaviors. Evaluations of IEC efforts show that print and audiovisual materials are of limited value beyond attracting short-term attention.

On the other hand, the next paragraph of that section properly emphasizes a focus on group activities at the local level. This should be given priority attention. As noted, whoever works on IEC activities at the community level needs training in community-based research methods, the elements of a sound IEC planning process, and group communication strategies.

Literacy training seems a questionable effort. To provide good literacy training takes time and resources to train trainers, organize classes, and provide reading materials. This is not to deny the importance of literacy, but primary school education is probably a more significant variable in increasing health awareness than literacy alone.

RECOMMENDATIONS:

25. The MOH should take the lead in molding its IEC team and contractor technicians into a partnership that will provide maximum support to community-based health education efforts throughout the country. The NPHSS should ensure that this team has the necessary logistical and material support to fully carry out its national mandate.

5.4 Contraceptive Supply and Logistics

As far as is known, USAID provides all contraceptives for Niger, aside from those brands which are imported and sold through private pharmacies. It is unlikely that the latter constitute a significant proportion. Procurement for the public sector and for supply to private voluntary organizations such as the Cooperative for Assistance and Relief Everywhere, International (CARE) is done by the Directorate of Family Planning (DPF), which distributes to Centre Nationale de Santé Familiale (CNSF), the AIDS program, and health centers. The Social Marketing for Change (SOMARC) project orders its contraceptives separately.

Table 2

CONTRACEPTIVES DELIVERED BY USAID
(Thousands [000's] of Units)

Year	Oral Contraceptives	Condoms	Injectables	IUD	Spermicides
1992	383	3588	68	14	1058
1993	1270	6774	78		964
1994	425	2004	50	2	206
TOTAL	2078	12366	196	16	2228
SOMARC		2202			
TOTAL DELIVERED	2078	14566	196	16	2228

Table 3

CONTRACEPTIVES DISTRIBUTED AND USED 1992-1994
(Thousands [000's] Units)

Year	Oral Contraceptives	Condoms	Injectables	IUD	Spermicides
TOTAL DELIVERED	2078	14566	196	16	2228
DISTRIBUTED	1431	9459	169	15	1649
USED*	1214	2666	136	6	644
STOCK IN DPF/SM	647	5107	27	1	579
STOCK IN SYSTEM	217	6793	33	9	1005

Data gathered by the Directorate of Family Planning (DPF) under the University Research Corporation (URC) program.

According to data from the DPF warehouse, there have been about 19 million contraceptives of all types received from USAID over the last three years, of which about 13 million have been issued to CNSF, the AIDS Program, and eight departments, including Niamey. The AIDS Program has received 2 million condoms over the three years, a relatively low figure compared to other AIDS programs in the region. They have also taken delivery of 172,000 spermicides.

There is some imbalance in the total quantity of contraceptives available for the period in question, the quantities recorded as distributed to the various programs, and the claimed usage by health centers. Certainly, there seems to be a considerable volume of condoms and spermicides unaccounted for in the system, and field observations showed that stock which was available was manufactured in 1991/1992. In other words, it is probable that the current "pipeline" in the system is considerably larger than the 15 percent assumed by USAID procurement.

It is also clear that due to the apparently low rate of usage, there is a grave danger of stock deteriorating before it has reached consumers. This is particularly true in the case of condoms. It may be, of course, that record keeping for stock issues, particularly of condoms and spermicides, is incomplete and that actual issue to the public is greater than reported. Implicitly, the difference between actual and claimed usage affects CYP for Niger.

Stocks appear to be readily available from the main DPF warehouse. Although Niamey and Tillaberi order stock on a quarterly basis, the other regions order only every six months and

sometimes fail to do this on a timely basis. Thus there are instances of lack of stock further down the chain, especially outside of Niamey.

In the case of ONPPC, which is responsible for distribution to Pharmacies Populaires (state pharmacies), although generic drugs seem to be well supplied, non-generics and contraceptives are often out of stock in the pharmacies. In addition, "Salles de Soins" and some of the agents in the private voluntary organization (PVO) sector are often without product. This is an important consideration. With efforts being made to encourage people to use contraceptives either for STDs/AIDS or for family planning, it is unacceptable for contraceptives to be unavailable when requested.

CYPs have grown steadily in recent years in Niger. At the end of 1994 CYP stood at 67,000 for the estimated 1.96 million women of reproductive age. If the unaccounted for condoms in the system are considered as having been distributed, this would add approximately another 25,000 CYP.

Oral contraceptives have accounted for the largest number of CYP over the years although they experienced a notable fallback in 1994, along with smaller reductions in use of intrauterine devices (IUD) and injectables. The most common explanation of this is that, due to labor strikes, women visited health centers in smaller numbers and thus the use of methods normally distributed from a clinic base suffered. At the same time, the advent of social marketing has dramatically increased the use of condoms.

Table 4

COUPLE YEARS OF PROTECTION
(Thousands [000's] Units)

Year	Oral Contraceptives	Condoms	Injectables	IUD	Spermicides	TOTAL
1990	16.0	3.3	3.2	5.5	1.9	29.9
1991	20.3	4.2	5.5	4.3	2.5	36.7
1992	26.6	5.0	8.3	5.4	2.4	47.8
1993	36.0	4.5	12.6	6.3	2.1	61.5
1994	30.6	17.1	12.6	4.6	2.0	67.0

Data gathered by DPF under the URC program.

It should be noted that under the new project, the definitions for CYPs have hardened. This should be taken into account when setting targets.

RECOMMENDATIONS:

26. Volumes of contraceptives being handled by the DPF warehouse and their distribution to the public and private sector agencies should be carefully examined to ensure that they are actually being distributed and issued to end users.

27. An audit of stocks at the various points of issue should be undertaken to ensure that products are not out of date before further requisitions are made through USAID/Washington. The computerized tracking system should be used to monitor distributions down to the level of health centers. Stock and sales recording systems should be incorporated into the SNIS system and TA commissioned to develop buffer stock levels and timely ordering.

5.5 Operations Research

5.5.1 Quality Assurance Project

The Quality Assurance Project (QAP) in Tahoua, the most successful OR initiative under the NFHDP, has been in existence since 1993 in a department with severely restricted resources and weak health infrastructure. The QAP methodology blends traditional quality assurance methods, emphasizing standard setting and performance monitoring, with a more comprehensive management approach which creates the systems, behaviors, and attitudes that favor continuous improvement.

The successful implementation of the QAP has been well documented, the impact of its innovations demonstrated through OR. National project counterparts, especially the Secretary General of the MOH, are pleased with USAID support to the Department and the continued high quality of TA offered by the project. They see the QAP as a tool with national potential for assessing the quality of management systems and service delivery, identifying problems and devising local solutions.

The QAP proved itself despite obstacles ranging from a difficult climate to rebel attacks, repeated labor strikes by civil servants, and the constant and debilitating turnover of key personnel. At the outset, project impetus was sustained through ready availability of technical assistance, but QAP has proven itself to counterparts who have seen objective results and the disappearance of blockages.

Still, there are areas that can be improved. For instance, financial institutions at regional and district levels are weak or nonexistent, so project funds must be managed by technical assistance

personnel. In keeping with decentralization, hiring budgets should be managed at the regional level, giving the regional health office authority to advertise and recruit on a competitive basis.

RECOMMENDATION:

28. As decentralization proceeds, there will be a continued need for operations research to test new models of program management and service delivery, new approaches to private sector programs or the financing of rural services. The Quality Assurance Project has proven the importance of OR, and substantial support for additional such initiatives should be provided under the new project.

5.6 Social Marketing

5.6.1 Background

The Futures Group, through the SOMARC project, began preliminary social marketing (SM) activities in Niger in 1992. Work carried out during 1993 resulted in the appointment of a resident advisor with GON experience and a local implementing agency, Association Conseil Pour L'Action (ACA), which had worked previously with USAID/Niger. ACA's responsibility is to manage the program, including packaging of products, and to carry out sales, distribution, and marketing activities on the ground.

SOMARC carried out basic research to confirm that proposed advertising and packaging would satisfactorily translate from other SOMARC markets to Niger. No major problems were found at that time. The SM element of the NHSS program was finally signed in December 1993, with the stated purpose of implementing the SM strategy for condoms, and to assess the feasibility of including other contraceptive methods in a later phase of the project. Recruitment and training of a sales force was effected by end of 1993 and a pilot test was carried out in one district of Niamey before the program was formally launched in April 1994.

5.6.2 Product and Pricing

At present only the SOMARC-branded PROTECTOR condom is being sold under the SM program. It is supplied free of charge by USAID, and a team of six people are employed by ACA for repackaging. This team packs about 12,000 units per day, which is well within the selling rate. Each pack contains three condoms which are sold to the trade in dispensers carrying 20 packets. Retail pricing is maintained at CFA 50 per packet.

Initially, ACA sold to the trade at a price of CFA 20 per packet of three condoms, giving retailers a margin of CFA 30. Out of ACA's CFA 20 margin they had to pay for salesmen's salaries, packaging and overhead, as well as subsidize the credit given by the sales teams. This pricing

structure was changed to one where the salesmen actually bought the product at a price of CFA 10 and sold it to the trade at CFA 25, thus making CFA 15 per pack profit in lieu of salary. The trade now makes a margin of CFA 25.

This move to commission-based selling provides the potential for much greater individual earnings, which is dependent on effort. In addition to the margin the salesmen make on product sales, there are additional bonuses for call rates, distribution gains, and promotional activities. The current payment structure, as in other SOMARC markets, has had a beneficial effect on sales team motivation and incentive.

5.6.3 Sales Organization and Volume

Initially there was one sales team of four people in Niamey, working under a supervisor. A second team was added in mid-1994 to work outside of Niamey. Sales teams are responsible for setting up distribution, promoting and selling condoms in suitable locations, usually discos, bars, and market places. Promotional travel is carefully planned, with up-country tours lasting about 10 days. The up-country team visits towns on market days, carrying out promotional events in the evenings. Most major towns are now visited once every two months.

Sales of products grew steadily during the first four months from launch, then increased rapidly on recruitment of additional sales staff and extension into regional areas. Marketing activity to this date had been through TV and radio, animations, public relations (PR) events, and the use of promotional materials. During October to December 1994, political elections were taking place and fundamentalist Muslim groups violently objected to the sale of condoms on religious grounds; this seriously disrupted the sales effort. A few stockists returned stock. Salesmen found it difficult to continue selling the products and, at times, were reluctant to do so. This produced a hiatus in sales which lasted about five months.

In April 1995 sales began to recover. With renewed distribution drives, sales are now running at a monthly rate of 100,000 condoms. In the first full year of sales, 710,000 condoms were sold, and the current running rate is about 1.2 million condoms per year. This makes 0.11 condoms per capita, which is very similar to other SOMARC programs in the West African region after their first year of operation (Appendix D).

5.6.4 Distribution

Distribution has grown over the period since launch. There are now some 3,600 outlets stocking PROTECTOR condoms, of which 2,600 are in Niamey. Core distribution nationally is in bars, hotels, and cafés, with all 19 private pharmacies stocking the product in urban or peri-urban areas. In Niamey about 45 percent of distribution points gained during 1995 were bars, cafes, hotels, and

restaurants, with a further 35 percent being boutiques or market stalls. The remaining distribution is with ambulant sellers.

This pattern is not reflected in the regions. Distribution is weak in the 33 Pharmacies Populaires (state pharmacies). The arrangement for sales to these outlets is that ACA sells to ONPPC, with whom pharmacists place their orders. The lack of stock in state pharmacies is mainly due to lethargy on the part of the pharmacist, and poor supply from ONPPC, especially outside Niamey.

Overall, the distribution tends to be in those outlets where young people or prostitutes gather, and where the motivation to purchase condoms is for prevention of AIDS and STDs rather than FP, although condoms do serve both functions. While inroads have been made into the more "mainstream" outlets in Niamey, much effort is required to extend this in regional towns. Failure to do this will only encourage a perceived attitude amongst ordinary Nigeriens that condoms are for casual sex purposes only.

5.6.5 Marketing

Initial marketing activities included use of mass media, public relations "sensibilisation" functions with influential people, promotional materials such as stickers, calendars, and T-shirts, and local animation/sensibilisation in places where young people gather. There have also been marketplace animations in the early stages of the project, but these were halted at the time of the active fundamentalist opposition. Since then, much work has been done in evaluating how to re-package the program.

The original TV advertisement was withdrawn and new material developed. SOMARC is working with two IEC committees. One is the official national committee, the second comprises 36 members drawn from many representative areas, including Islamic groups, health workers, journalists, and GON representatives. The approach now is to design locally appropriate sketches for radio, lasting between three and 10 minutes. They will also be filmed and on video equipment in animations. This will provide a test of reaction to the films as well as be a useful medium for small group communication.

5.6.6 Constraints

The problems raised by Islamic group protests have undoubtedly affected the progress of the SM project and are worthy of comment. There are several possible reasons for the Islamic groups' objections. One is that the advertising itself may have been offensive in style. Another could be the use of mass media for the promotion of condoms, as opposed to more discreet methods. Some sectors of Nigerien society object to FP per se, especially when nationally promoted. Lastly, at a time of national elections this was a high visibility target, which raised the profile of minority groups.

SOMARC adapted its advertising from that developed for use in Zimbabwe, which has been used without major problems in other West African countries. The use of cartoon characters overcomes the problem of nationalistic identification, which sometimes may be a negative. It is possible that this route was a bit insensitive to the conservative Nigerien culture. But the ad pretested without major rejection and was aired for six months without complaint.

The impact of Islamic groups' objections was that the mass media campaign was halted, temporarily removing one of the main planks of the SM program. Some traders who had stock were reluctant to continue selling PROTECTOR condoms because of peer group pressure, and other traders were cautious about stocking the product for the first time. The sales team was also hampered by having to travel together, rather than individually, for safety, and much sales effort was wasted for about five months.

The problem has now been addressed and communication activities are being developed in a more sensitive way. Sales are becoming buoyant again and several sectors of the trade appear to have sufficient confidence in the project to stock the product. Sell-through appears to be developing well, but unless the open market trade begins to accept the product as "normal" then PROTECTOR condoms may be in danger of becoming overly associated with the prevention of AIDS and STDs, as opposed to family planning.

5.6.7 Conclusions

The SM project has made a good start and is adding a dimension to the promotion of contraception that was hitherto not available in Niger. After one year, per capita sales volume is at a level similar to other countries where SOMARC operates. Distribution is developing steadily, but because of its focus on those outlets where the product is more likely to be purchased for casual sex, it may become entrenched as a high risk group product, rather than one for use by the general public.

Support for the project and generic activity on the part of GON will help the SM program considerably, as will coordination with other outreach groups. The latter can fulfill an essential role in providing education and distribution to complement SM activities, which will in turn make the product category and concept one of everyday acceptability.

RECOMMENDATIONS:

29. The social marketing program must make every effort to gain distribution in non-AIDS/STD outlets in order to normalize the product and gain public acceptance. GON should communicate the FP and AIDS/STD prevention messages in a generic way, in conjunction with the branded SM activity. This will require IEC coordination to ensure common messages.

30. USAID should encourage the GON to move legislation which would allow other products such as vitamins and oral rehydration solution (ORS) to be sold via the SM distribution system, eventually leading to open sale of OC's. This will help the SM program become more self sustaining and will aid acceptance of contraceptives on the open market.

31. The SM program should publicly market and distribute its products where it can economically do so, and link up with other community-based distribution (CBD) activities to gain access to the chain of activity down to village areas. USAID should ensure that practical programmatic interfaces occur.

5.7 PVOs, NGOs, and the Private Sector

There are various private sector health projects and services operating in different parts of Niger, enough to attest to the potential of the private sector to provide an important, energizing counterpart to public sector programs. Many of these activities are under the auspices of international private organizations. Other international groups are also active, as are a small number of Nigerien NGOs, such as ACA (see 5.6.1 above).

Three U.S. PVOs with local offices and substantial programs are CARE International, Africare, and Helen Keller International (HKI). Each received support from the NFHDP, and the operations of each has recently been evaluated. Thus the focus of the evaluation team was on familiarization with project activities and the lessons to be learned from them for the future, rather than on a detailed analysis of the past. The team also strongly supports all of the specific objectives/activities for energizing the private sector that are proposed in the RFP for the new project.

5.7.1 CARE International

CARE's health and family planning programs in Zinder have tested various approaches to increased health and family planning coverage at the village level. They support "opinion leaders" and village health agents (ASVs) as providers of contraceptive information in villages not covered by MOH facilities. In villages that are covered, CARE has experimented with different types of budgetary or equipment support. While awareness of the importance of family planning, immunizations, and other primary health practices has risen, and studies have shown a measurable increase in contraceptive prevalence, access to and quality of services remain problems in most of the region.

This makes CARE's establishment of a semiprivate, rural health center in an underserved area particularly interesting. Facilitated with seed money from CARE headquarters, and planned entirely by the community, the facility is expected to open in the fall of 1995. Its functioning will depend in large part on community support, making it the first such private sector initiative in

Niger. It should be watched carefully and, if successful, used as a model for other private or semiprivate services that could begin to fill the huge gaps in access to services that prevail in most of rural Niger.

CARE's other major initiative in Niger is its credit program in Maradi. With three components—a loan program for small business start-ups, technical training for potential entrepreneurs, and a village womens' credit network modeled loosely after the Grameen Bank—it has become a significant laboratory for approaches to private sector financing and a clear illustration of Nigerien interest in putting money to work. Lessons from the Maradi credit programs should be made widely available to individuals and NGOs seeking to open private sector health services. They can also provide an interface between projects supported under USAID's S.O.1 and S.O.2, and permit mutual reinforcement.

5.7.2 Helen Keller International (HKI)

HKI has supported vitamin A programs in Tahoua and Maradi since 1986. These were extended to include Zinder and Dosso between 1992-1995 and a third phase is in the process of development. Despite much effort in sensibilisation and IEC for the provision of vitamin A through local products, and free distribution of manufactured products, the projects have had limited success. They are hampered by lack of support in the form of Government interest and by shortage of funds and transportation for follow up.

The HKI representative in Maradi was especially unhappy about his inability to do adequate follow up in the region. It occurred to the evaluation team that if other organizations active in the region, such as CARE which has a large fleet of motorbikes for its credit agents, knew of HKI's rural transport difficulties, some appropriate assistance might be worked out. Again, more communication among programs can only be beneficial.

5.7.3 Africare

Africare has supported a variety of agricultural and child survival projects in the Diffa Region since the late 1970s. Recent evaluations pointed up severe problems in Africare's child survival program, especially with personnel and poor local government relations. The question might logically be asked as to whether, after such a long time, it would make sense to look elsewhere.

However, the evaluation team was impressed with the new Africare Project Coordinator in Diffa, a Zairois with extensive experience in developing community-based health and development programs. He clearly has turned the project around, broadening the range of its interventions beyond health, generating community commitment and improving working relationships with local government authorities. As remote as it is, Diffa may nevertheless have something to show other parts of the country in terms of low-cost, community-ran programs. It would seem, for example,

to have much to learn from and contribute to the Quality Assurance Project in Tahoua. Integrating Diffa, and Africare, more into the national scene should pay dividends for everyone.

5.7.4 Additional Observations

The RFP for the new USAID population and health project lists reasonable goals and strategies for private sector development in Niger. All are enthusiastically endorsed by the evaluation team. While still small, the Nigerien private sector is energetic and ready to make the most of innovative financing schemes. It has the potential of becoming a creative laboratory for and competitor to public sector health and family planning programs.

USAID-funded PVOs, along with GTZ (Association for Technical Cooperation, Germany), UNICEF, and others, will be the principal source of support for private sector initiatives for the time being, but successful models should increasingly be used to spark government interest and support. While laws defining private sector health services are still in the process of being enacted, the climate is increasingly supportive and services of many types and sizes already exist, especially in Niamey and other large towns.

RECOMMENDATIONS:

32. Establishment and expansion of health facilities and services in the private sector should be vigorously encouraged through access to credit, publication of guidelines and regulations, and private sector-oriented training. This is a resource ready for dynamic growth.

33. USAID should construct its programs whereby donor activities complement each other, minimize duplication of effort, and develop a coherent private sector strategy. Regular communications of both design and progress of programs should be set up among all private sector donors.

6. CONTRACTOR PERFORMANCE

The following summary comments are intended to supplement, not replace, the many specific observations on the performance of contractors responsible for the NHSSG and NFHDP which are contained throughout this report.

6.1 NHSSG

The principal contractor was Tulane University, in close collaboration with Abt Associates, and with technical assistance in accounting systems provided by Deloitte and Touche, an accounting firm based in Accra, Ghana.

The evaluators were impressed with the competence and cohesion of this team. Building on Tulane's long association with the Nigerien health community (more Nigerien health professionals have probably been trained at Tulane than any other United States institution), it brought energy and skill to a complex and often frustrating task with clearly positive results.

During the final two to three years of the grant, when more realistic project goals were agreed upon, the Tulane/Abt team achieved important successes. These included establishment of the SNIS, completion of milestone cost-recovery initiatives, and a vigorous population policy dialogue. Again, these accomplishments, the obstacles they overcame, and specific suggestions for the future appear throughout this report.

The evaluators were struck by the contractor's belief, specifically stated, that continued long-term technical assistance for Nigerien health systems is inevitable. The contractor felt that this was reflected in a less than total commitment to the training of counterparts to the level of outside specialists, and to the ultimate obviating of the need for such specialists. (See Section 3.3.) The team also faulted the contractor for not doing more to coordinate and share lessons with other donor groups, especially the NFHDP contractors. By its own admission, the contractor did not feel this was a priority.

On the other hand, the Tulane/Abt team established and maintained excellent working relationships with their counterpart GON agencies, in Niamey and around the country. These partnerships were in large measure responsible for a generally successful mission.

6.2 NFHDP

The major contractor for this project was the University Research Corporation (URC). Also implementing specific projects under the project were the three United States PVOs with resident operations in Niger, CARE, Africare, and HKI. Groups providing limited inputs and not based in

Niger were Family Health International (FHI), DHS, JHPIEGO, OPTIONS, and SOMARC. Each of the latter effectively filled its particular niche under the NFHDP in ways described in the body of this report.

The evaluation team felt that the major weakness with this contractor group, inherent in the very number of actors, was its diffused nature. Each entity "did its own thing," and there was little apparent intercommunication or sharing, at least among the principal players. As by far the largest contractor, URC should probably be most specifically criticized for this. Yet it is unclear whether it was responsible for playing any coordinating role.

Since all resident URC personnel had left Niger before the evaluation team arrived, we were unable to pursue this issue in Niger. But it seemed to the team that this situation mirrored the broader concern about donor coordination. Agencies funded under one umbrella should have known more about each other's programs, and done more to share their successes and failures. Because of the lack of such contact, opportunities must have been surely lost.

That said, URC also deserves to be commended for hard work and significant successes. With URC's support, the DPF has planned and implemented a national family planning program which, while it still has profound weaknesses, is present and known nationwide. URC-sponsored training has strengthened the body of personnel that will be responsible for implementing a decentralized MOH program. The Quality Assurance Project in Tahoua has been a notable success; one that the Ministry hopes to replicate around the country. In short, URC can take considerable credit for helping to bring Niger to the present point of departure for its national program.

CARE International's program is described above. It is innovative and productive and should be better known. CARE's operations are so decentralized that its own individual projects are not fully familiar with each other, let alone known to others. CARE should make more effort to communicate its ideas and the results of its "works in progress," especially in the areas of credit and private sector service development, to fellow agencies and especially the GON.

As noted above, Africare has a new lease on life for its troubled program in Diffa. Thanks to skilled, new leadership, in both Diffa and the person of its new country director. But years of working so far on the margin of the country have tended to marginalize its accomplishments. It should do more to communicate with other areas and programs, and to put the Diffa community-based experience forward as a laboratory from which others can benefit at a time when community orientation is so important.

HKI has achieved documented success within a limited program. Again, the team hopes that HKI will do all that it can to make its proven models available to a wider audience, especially to a Ministry of Health that is seeking community-based approaches to communication and service delivery.

7. REFLECTIONS ON USAID PROGRAM LEADERSHIP

Thanks in large part to the projects that are the subject of this evaluation, the Government of Niger does indeed appear to be at a point of departure for a reinvigorated, decentralized national health and population program. At the same time, USAID/Niger has positioned itself to be both a supportive partner and driving force behind this effort.

The evaluation team was impressed with the combination of deep commitment and hardheaded analysis that has clearly gone into the development of USAID's Strategic Objectives approach. Beyond mere substitution of one jargon for another, it bespeaks a highly refined awareness of the political and practical realities of foreign assistance today, and of the need to be crystal clear as to what one hopes to accomplish, and how.

We strongly support USAID's emphasis on concepts of partnership, teamwork, and collaborative strategy development, especially as illustrated in its dealings with the government. In this regard, it is fair to say that our recommendations on coordination and sharing of ideas, resources and lessons learned are among our most strongly felt. It is messier than "going it alone," more time consuming than carving out one's own turf and keeping others away. But the payoff in terms of capacity building, counterpart respect,
and the minimization of lost opportunities cannot be overstated.

Clearly, the Mission understands this, not least through its welcoming of senior Nigerien professionals to its staff. We hope that the Mission can transmit this philosophy repeatedly and unambiguously to all of its grantees and fellow development agencies.

One thing which gives us pause is the heavy emphasis on results. The political and economic realities behind a "results orientation" are obvious. Yet in a fragile environment, where talent is still thin and progress often measured in very small steps, an overemphasis on tangible outputs, especially in the short term, risks engendering a sense of failure. When that happens, momentum is stifled even before it takes hold.

APPENDIX A

SCOPE OF WORK

WORK SCHEDULE

The entire team will be contracted for four weeks and the Team Leader/Editor will be contracted for five weeks in order to complete the final report. The evaluation team of six persons will be split into two sub-groups to be determined by the Team Leader and USAID. The team will spend three full days in Washington, D.C. participating in a team-building exercise and interviewing key people by phone after which they will leave for Niamey. Upon arrival in Niamey, the team will be briefed by USAID/Niger and continue team-building with their four Nigerien counterparts and participate in meetings at the Mission, GON Ministries and other offices deemed pertinent. The team will then proceed to field visits (to be determined later) for one week. Following their return to Niamey, the team will prepare a status report and hold a half-day debriefing and discussion for GON, USAID/Niger, USAID stakeholders and project personnel on their findings, preliminary conclusions and lessons learned. They will then have the remainder of the week to prepare a first draft of their report which will be submitted two days prior to the team departing Niger. The team leader and possibly one other team member will remain in Niamey for one additional week to complete work on the draft document, incorporating comments made by the Mission, the GON and other stakeholders, and submitting the final draft before departure. The Mission will return the draft to Poptech with comments where it will undergo final editing in Arlington by Poptech staff, and be submitted to the Mission within four weeks of receipt of Mission comments.

Week 1	
Travel to Washington	Tuesday
Washington: Team building meeting	Wednesday-Thursday
Phone calls/interviews	Friday
Travel to Niamey	Saturday-Sunday
Week 2	
Orientation/team building with counterparts	Monday
Meetings in Niamey	Tuesday-Friday
Travel to field	Saturday-Sunday
Week 3	
Field visits	Monday-Friday
Return to Niamey	Saturday-Sunday
Week 4	
Team meeting	Monday
Debriefing	Tuesday
First Draft Report	Wednesday-Saturday
Team departs	Sunday
Week 5 (Team Leader only)	
Final Draft Report (Team Leader/editor)	Monday-Saturday
Team Leader/Editor departs	Sunday

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DELIVERABLES

Status Report: A status report showing preliminary findings and conclusions will be submitted to USAID/Niger one week before team departs and used for debriefing the Mission, GON and others.

First Draft of Report: English and French versions of the first draft must be submitted no later than two days prior to team departure. USAID/Niger will review the draft and respond with comments within four days of receiving it.

Final Draft of Report: A final draft, in English and French, detailing principle findings, conclusions and recommendations and reflecting comments and changes requested by USAID/Niger and the GON must be received prior to the Team Leader/Editor departing Niger. Both hard copy and an electronic file in Wordperfect 5.2 of the final draft must be submitted.

Final Report: The final report is to be received by USAID/Niger not later than four weeks after the team has departed Niger. The Team Leader is responsible for seeing that the report is completed in a timely manner, incorporates all of the USAID/Niger and GON comments, and conforms to the reporting guidelines required (see section on Reporting Requirements).

GON Counterpart Report: In addition to the final report, the Nigerien team members are asked to submit a report detailing their recommendations regarding USAID/Niger and the Government of Niger counterpart collaboration for any future project.

METHODS AND PROCEDURES

USAID/Niger will supply a reading list to Poptech for the evaluation team no later than one month prior to the start of the contract. Poptech will prepare a briefing document for the evaluation team prior to the team's arrival in Washington. The evaluation will be carried out over a five-week period beginning in August 1995. The team will work under the guidance of the Mission Health Development Officer or his designee. One member of the team must be designated as leader. The Mission NFHDP and NHSS Program Coordinators and Controller staff will also provide assistance to facilitate the team's work. The team will work in collaboration with designated Nigerien counterparts, as appropriate. A six-day work week will be authorized for the in-country fieldwork phase of the evaluation. Since the team will travel to and from Niamey on weekends, per diem will be paid for a seven-day week.

The team will conduct the evaluation of these two projects through document review, interviews and site visits. Evidence for findings and conclusions will be based on: 1) review of USAID and GON documents; reports, studies, evaluations, surveys; national health and population data; National Health Information Systems (SNIS) data; service statistics; GON Five-year Plan; medical school, ENSP, and ENICAS records (tests, reports) and curricula; and contractor project documents; 2) field trips; and 3) interviews with Mission project officers, GON counterparts, project contractors, USAID stakeholders, field staff and clients. The team is not expected to generate new data for any of its reports, but reanalysis of existing data may be appropriate.

USAID/Niger will provide the following logistic support: accommodation exchange for U.S. citizens; airport expeditor service; hotel reservations; and health unit services.

The contractor will be responsible for all local and international travel arrangements and other support including computer support, photocopying, communications, secretarial and language translation. The contractor will also be responsible for payment of all internal travel and per diem, and honoraria, according to USAID regulations, to Nigerien participants on the team.

COMPOSITION OF EVALUATION TEAM (6 persons)

This evaluation requires six senior level professionals who must have: 1) an advanced degree with preference given to a doctorate; 2) five years developing country experience in their field, preferably with USAID and; 3) speaking and writing skills in French (level FSI 3/3). USAID/Niger recommends the following mix of expertise and individual experience, but is open to recommendations for different combinations of skills and experience if deemed more appropriate.

Specific Responsibilities and Qualifications of Team Members

1) Team Leader/Policy Specialist/Editor: The Team Leader/Policy Specialist/Editor will have overall supervision responsibilities for the execution of the evaluation. This individual will finalize the work methodology and work schedule; assign sub-groups and team tasks related to the proposed individual scopes of work; review current GON policies regarding health and family planning and the identify policy areas in need of change; synthesize team findings based on document reviews, individual reports and analyses, team reports and field trips; undertake the final review and submit the completed evaluation report to USAID/Niger.

The individual should have at least a master's degree in public health or public administration, or related complimentary field training or experience in health and family planning management and established expertise in conducting evaluations, preferably for USAID. Requires a strong background in health and population policy analysis/research; eight to ten years experience working with USAID health and population projects/programs with previous project/program design and evaluation experience; proven ability to work well with other nationalities; ability to exercise leadership and engage in policy discussions at high levels; proven supervision skills and previous African experience. The candidate must have strong writing skills. The Team Leader/Policy Specialist/Editor will be hired for 5 weeks.

2) Health Economist/Financial Analyst: The Health Economist/Financial Analyst will be responsible for undertaking all financial and economic analysis.

This individual should have at least a master's degree in economics, with an emphasis in health economics. The candidate should have at least five years working in applied health economics studies and policy development and implementation, with at least three years working in developing countries, preferably in francophone West Africa.

3) Management/Human Resources Specialist: The Management/Human Resources Specialist will be responsible for addressing all elements of the projects that concern management and supervision as well as human resource development.

This individual should have at least a master's degree in health administration/management, business management or human resource development with complimentary training in a health-related field. The candidate should have a strong background in public health administration in a developing country setting, preferably in francophone West Africa.

4) Service Delivery Specialist/PVO Specialist: The Service Delivery Specialist/PVO Specialist will be responsible for addressing all aspects concerning the expansion of family planning and basic health services as well as evaluating the elements of the projects administered by the PVOs and non-governmental health services.

This individual should have a Ph.D. or master's degree in economic development, health economics, business or another field relevant to private sector health services; professional experience in private health services delivery; experience in project/program design and implementation of private health services in a developing country; and experience working with international PVOs/NGOs. This person should be field-oriented with experience in private sector promotion in a developing country setting, preferably in francophone West Africa.

5) IE&C/Training Specialist: The IE&C/Training Specialist will be responsible for assessing the capacity of the GON and contractors to develop and promote IE&C and implement clinical service training programs.

This individual should have a master's degree in communications with strong health education and training background. At least five years' related field experience, preferably in francophone West Africa, in the design, execution and implementation of family planning and maternal and child health IE&C materials and programs. Experience in interpersonal communication/counselling is desirable.

6) Private Sector/Social Marketing Specialist: The Private Sector/Social Marketing Specialist will be responsible for evaluating the elements of the projects that relate to the private/commercial-sector health services, including pharmaceutical and contraceptive distribution.

This individual should have a Ph.D. or master's degree in economic development, health economics, business or another field relevant to private sector health services; professional experience in private health services delivery; and experience in project/program design and implementation of private health services and social marketing programs in a developing country. This person should be field-oriented with experience in private sector promotion and income generation in a developing country setting, preferably in francophone West Africa.

REPORTING REQUIREMENTS

Report Format
The team will be required to prepare a written document containing the following sections:

Executive Summary: which is to be a maximum of two pages, single-spaced.

Project Identification Data Facesheet

Statement of Conclusion and Recommendations: the conclusion is to be short and succinct, with the topic identified by a short sub-heading related to the questions posed in this SOW. Recommendations must correspond to the conclusions and, whenever possible, the recommendations will specify who, or what agency, should take the recommended actions.

Body of the Report: which includes a description of the country context in which the project was developed and carried out, and provides the information (evidence and analysis) on which the conclusion and recommendations are based. The report should have an executive summary, one introduction covering both projects, separate sections for each of the two projects detailing the team's findings and specific conclusions arrived at during the evaluation, lists of all individuals interviewed and documents consulted, and a summary of recommendations (maximum of 40 pages).

Appendices: which includes at a minimum the ESOW; a brief summary of the current status and attainment of original or modified inputs and outputs if these are not already indicated in the body of the report; description of the methodology used in the evaluation; bibliography of documents reviewed; list of agencies contacted and individuals interviewed; [etc.]

Submission of the Report
The evaluation team will be required to submit six copies of the final report, three in English and three in French. Within four weeks of receipt of Mission comments on the final draft, the contractor must transmit the final report (all six copies) to USAID/Niger. It is the responsibility of the Team Leader to ensure the report is completed and submitted in a professional and timely manner. The contractor is responsible for translating the complete report into French before submitting them for final review.

Debriefing
One week before the team departs they will be required to debrief the Mission, GON and others deemed appropriate by USAID/Niger, on their preliminary findings, recommendations and lessons learned.

Completion of the AID Evaluation Form (AES): The AID/S/PHN Officer will be responsible, in conjunction with the DEO, for completing the AES. DEO will be responsible for submitting the completed form to USAID/W.

COLLABORATING AGENCIES

Niger Health Sector Support Grant:

Tulane-Abt (primary institutional contractor)
Family Health International

Family Health and Demography Project:

University Research Corporation (primary institutional contractor)
Futures Group/OPTIONS
Futures Group/SOMARC
Africare
CARE International
Helen Keller International
Johns Hopkins University/JHPIEGO
Demographic Health Surveys (DHS)
Family Health International/AIDSCAP

APPENDIX B

LIST OF PERSONS CONTACTED

EVALUATION TEAM COUNTERPARTS:

Dr Aissa B. Ado, Ministere de la Sante Publique
Mr Seydou Idrissa, Ministere des Finances et du Plan
Mr Felix Lompo, Direction de Population
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USAID/NIGER:

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Gary Merritt, Program Officer
Dan Blumhagen, Chief PHNO
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Kirk Lazell, PHNO
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Oumarou Kane, PHNO
Dr. Hamissu Maoude, PHNO

DONORS:

WORLD BANK

Pierre Nignon , Program Officer
Dr Halima Maidouka, Population Project Coordinator

UNDP

Abdoulaye Janneh, Resident Representative

UNFPA

Alissatou Sanoussi Goune, Coordinator, Economist
Ouassa Djatao, Technical consultant

UNICEF

Georgette A. Aithnard, Resident Representative
Agatha Pratt, Health Project Officer
Eric Donelli, Assistant Project Officer

W H O

Dr Yankalbe, Resident Representative
Dr Maurice Ramakavelo,Technical advisor at CNSF
Dia El Housseynou, UN Volunteer at PNLS/MST

GERMAN COOPERATION:

Mary White-Kaba, GTZ, Projet Alafia Coordinator

COOPERATING AGENCIES:

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FUTURES GROUP/SOMARC:

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Mike Godfrey, Director, CARE in Niger
Dr. Sani Aliou, Chef, Projet Sante, Zinder
Zakari Madougou, Regional Director, Maradi
Cheik Mhd. Sangare, Directeur Operations, BRK, Maradi

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Colette Geslin, Medical Resident Advisor

HELEN KELLER INTERNATIONAL (HKI):

Boubacar Issa Camara, Program Director
Dr. Chano Hamidan, Reg. Coordinator, Maradi

AFRICARE:

Natascha Yudith Cadet, Administrative Assistant
Aaron Marshall, Resident Representative, Niger
Muderhwa Runesha, Coordinateur, Diffa Project

GOVERNMENT OF NIGER:

MINISTERE DU FINANCE ET PLAN

Amadou Saidou, Deputy General Secretary

MINISTERE DU DEVELOPPEMENT SOCIAL, POPULATION ET FEMMES

Garba Bassirou, Director of Population (DP)
Morou Halidou, Division Etudes et Recherches/DP
Barra Bahari, Service IEC/DP
The members of Reseau National de Techniciens IEC
The members of Comite National IEC

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Mr Aboubacar, Epidem. Surveillance Center Tahoua
Dr Abani A. Maazou, Chief, Health District Tahoua, and Staff
The staff, Property Management and Repair (SERAM), Tahoua
The staff of medical post of Malbaza, Tahoua
The staff of medical post of Birni Konni

Dr. Kadade Goumbi, DDS, Maradi
Dr Sani Issa, Pharmacist Bamako Initiative, DDS Maradi
Mr Jadi Magaji, Deputy Director DDS Maradi
Mr Illa Djibrilla, Reproductive Health Coordinator
Mr Maina Sara, MCH/FP Coordinator

CIMEFOR Staff in Dogondoutchi, Dosso
Staff, CM's of Boboye, Say and Ilela
MC, Chefs DR, CM of Madoua

Pharmacists in IDOSSO, GAYA, MARADI, ZINDER, and NIAMEY

APPENDIX C

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APPENDIX D

REPRESENTATIVE SOCIAL MARKETING STATISTICS

CONDOM SALES ACHIEVEMENTS IN WEST AFRICA

SALES OF CONDOMS INTO TRADE -(000's)

COUNTRY	1989	1990	1991	1992	1993	1994
BURKINA FASO [1]				4528	2485	4600
COTE D'IVOIRE [2]				7164	6635	8000
CAMEROUN [3]	729	1959	3004	5314	5706	6500
TOGO [4]				410	1019	2500
NIGER [5]						660
MALI				678	1049	2195
GHANA	3214	3587	3748	4027	4290	4500
NIGERIA		2000	3000	5000	24000	60000

Although the projects commenced at slightly different times, the above table indicates annualized sales for the fiscal years shown. The figures for 1994 are based on information to date plus an estimate to year's end.

Notes:

1. Heavy sell-in and regional roll-out makes first year sales look good. Second year drop was due to moving blocked stock and low volume sales of new product as distribution was concentrated on the less populated rural regions. 1994 rate represents likely current consumer offtake.

2. Heavy trade stocking in first year led to stockpiling with consequent decrease of sales in the second year. 1994 sales level is probably near consumer offtake but there is evidence of product being moved outside Cote d'Ivoire so the rate does not necessarily reflect exact internal Ivoirien consumer demand.

3. Relaunch of PRUDENCE Plus in 1992 increased sales in that year. About 5% of annual sales for 1992/3/4 are for Promesse, a second brand. About 6% of sales are going cross-border to Guinea and Chad.

4. Sales in 1992/93 were affected by stock shortages and a political crisis which effectively stopped sales for 3 months in early 1993. Because of high local retail price and stock shortages in the market, imports from Benin and Ghana were very evident during first half of 1993. The retail price was halved in mid-1993 which promoted heavy trade buying, and resulted in several months stock shortages from USAID. Stocks are now under control and because of devaluation of FCFA against Cedi, about 30% of current year sales is going to Ghana. 1994 rate for internal consumer sale was probably about 2.5 million p.a.

5. Program commenced April 1994. Sales estimate for 1995: 1.2 million.

SALES OF CONDOMS/CAPITA

COUNTRY	1989	1990	1991	1992	1993	1994
BURKINA FASO				0.48	0.25	0.46
COTE D'IVOIRE				0.56	0.50	0.58
CAMEROUN	0.07	0.17	0.25	0.43	0.45	0.50 [1]
TOGO				0.11	0.26	0.63 [2]
NIGER						0.08 [5]
MALI				0.07	0.10	0.21 [3]
GHANA	0.21	0.23	0.24	0.25	0.26	0.27
NIGERIA		0.02	0.04	0.06	0.27	0.67 [4]

Rates per capita are derived from sales **into** the trade and population estimates from published statistics. Despite overstocking, stockouts and other trade problems, per capita sales after three years are still only about 0.5 condoms/head/annum. Even if the population base for these calculations were limited to males of active reproductive age the number would rise to only 1.75 condoms/head/annum. Although this may be a major improvement on condom usage prior to the commencement of social marketing programs, the usage rate is still low.

Notes:

1. Estimated consumer rate - 0.47.

2. Estimated internal country consumer rate - 0.44.

3. Lower rate than other markets after three years due to focus of product on FP rather than AIDS/STD's, and conservative market.

4. Considerable cross border traffic to all West Africa markets. Internal consumer rate not known.

5. The rate for Niger is currently running at 0.11 for 1995 and is similar to other SOMARC programs at this stage.